GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR
PROPOSED FY 17 BUDGET

DHCF Budget Presentation For FY2017

Presentation for:

Medical Care Advisory Committee

Department of Health Care Finance

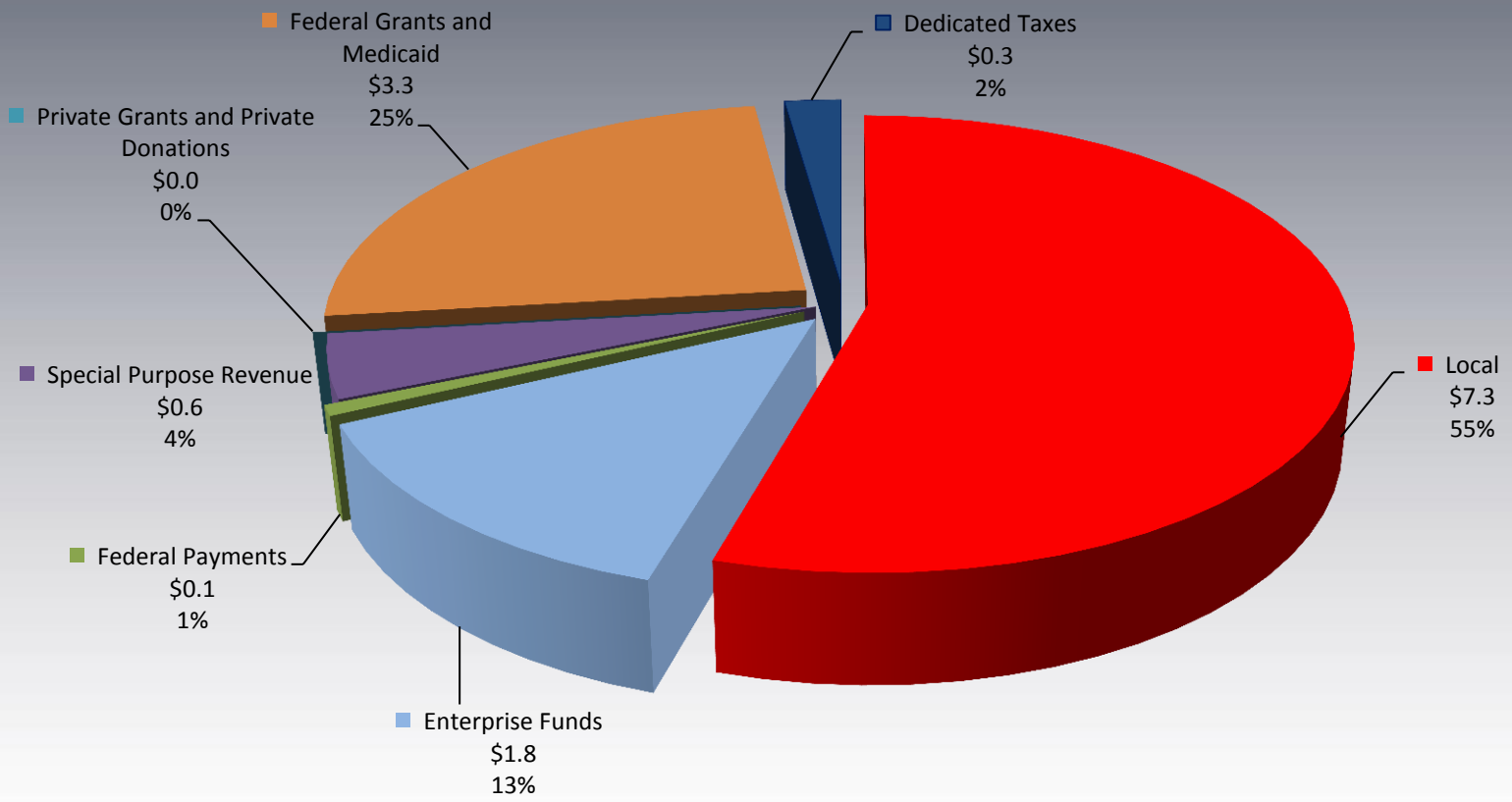
March 2016
Washington DC

- [x] **Overview Of District's Budget For FY2015**
- [ ] Budget Development For DHCF
- [ ] Medicaid And Alliance Enrollment Trends
- [ ] Status Of Automated Medicaid Eligibility System
- [ ] Medicaid Acute Care Expenditure Patterns
- [ ] Medicaid Long-Term Care Expenditure Patterns
- [ ] DHCF's Major Activities Planned For FY2017

The Approach: A Priority Driven Budget

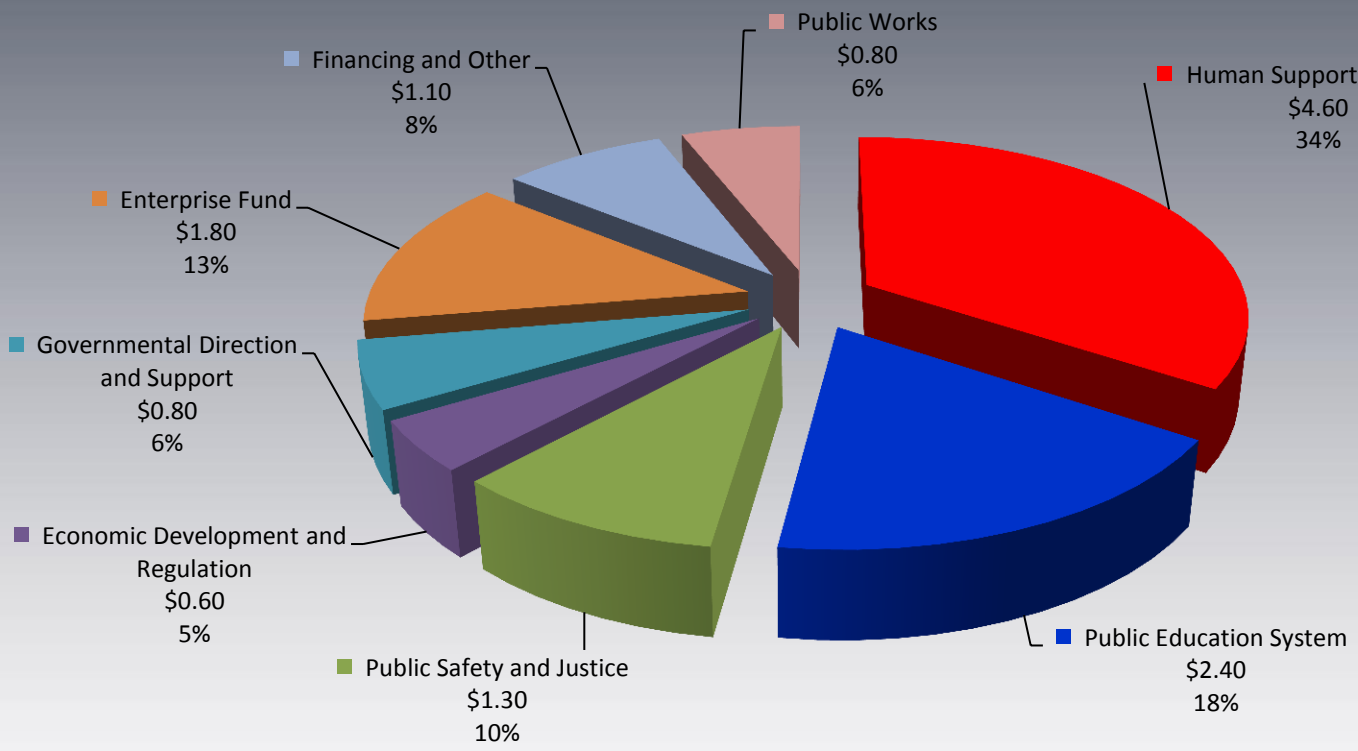
- Engage with the public and solicit their input about community priorities
- Challenge Agency Directors to Fund Priorities First, like:
  - Job Training, Affordable Housing and Education
- Target underspending, vacancies, and program inefficiencies, not across-the-board cuts
- Maintain and invest in the District's workforce
- Preserve **middle class** tax reductions

Sources of Gross funds for FY 2017
($13.4 Billion, Excluding Intra-District Funds)



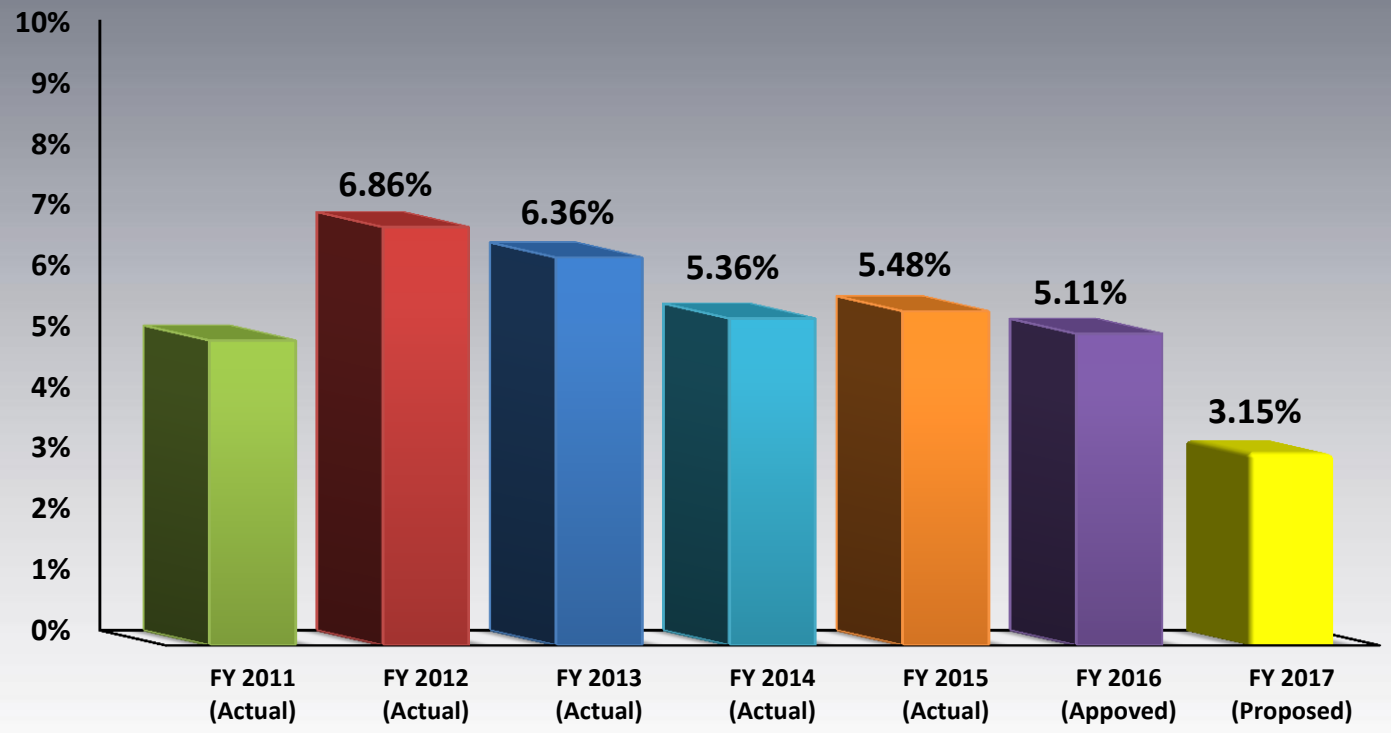
*Private Grants & Donations is $1.3 million

Gross funds Expenditure Budget for FY 2017 (Excluding Intra-District Funds) ($13.4 Billion)



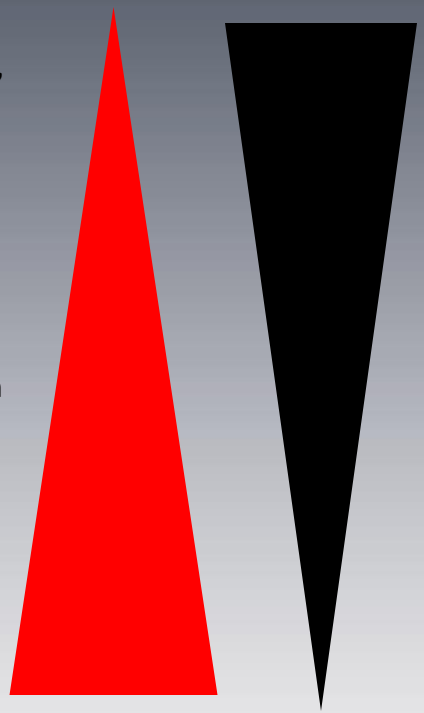
Budget Growth

FY2011 - FY2017 LOCAL FUND BUDGET GROWTH



COSTS PROJECTED TO RISE 4.3%,

- Personnel, Fringe & Retirement - $75.9 million
- Contract inflation - $70.8 million
- Medicaid - $25.8 million
- DCPS and DCPCS - $28.1 million
- Debt Service - $12.8 million
- PAYGO not in CSFL - $46.4 million
- Other - $10.9 million



REVENUES PROJECTED TO INCREASE 1.3%

- **Retirement Savings of $64.4 million**
- **Special Purpose Revenue Sweeps of $50 million**
- **One Time Savings Consisting of $76 million in CSFL Reductions, including:**
  - **Department of General Services, $31 million alignment of fixed costs**
  - **Health Care Finance, Health Care Finance, $7.2 million from efficiency savings due to processing some Federally Qualified Health Center payments by DHCF's claims vendor instead of through the Medicaid managed care plans.**
  - **Public Libraries, $2 million from supplies, materials, contractual services, and vacancy savings**
  - **Aging, $1.3 million from re-alignment of DCOA's transportation program**
  - **Disability Services, $2.6 million from vacancies, shifts to Medicaid, and rightsizing contracts**
  - **DDOT - $12 million shift fund shift (Local to O-Type funds)**
  - **WMATA - $6.3 million shift to SPR and dedicated taxes**

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(dollars in thousands)

DHCF Budget

	FY16 Approved Budget	FY17 Proposed Budget	% Change
Personnel Services	25,955	25,336	-2.39%
Fixed Costs	756	978	29.4%
Other Non-Personnel Services	2,061	3,204	35.7%
Contractual Services	71,478	79,439	11.1%

FTE FY16 original budget 251
FTE FY 16 revised budget 251
FTE FY17 proposed budget 250

Less 1 Position in FY 2017 (net change)
+1 position in the Agency Mgmt. Program
-2 positions caused by the expiration of the State Innovation Model Grant

Increase driven by higher assessments for occupancy, security services, electricity, and water.

Increase due mainly to the OCTO IT Assessment, Telecommunication costs, and IT Hardware Acquisitions.

Increase due mainly to OCP MOU (+$1.1M), higher contract costs in HCDMA (+3.5M) and Long Term Care (+1.3M), and larger contracts in support of the HIT/HIE PMO (+$2M).

FY 17

(dollars in thousands)

Funds	FY2016 Approved	FY2017 Proposed	% Change
Local Funds	700,011	706,421	0.92%
Dedicated Taxes	71,345	81,907	14.80%
Special Purpose Revenue	2,605	3,493	34.09%
Total General Funds	773,961	791,821	2.31%
Federal Grant Funds	1,000	2,916	191.61%
Federal Medicaid Funds	2,146,166	2,188,106	1.95%
Total Federal Funds	2,147,166	2,191,023	2.04%
Intra District Funds	84,327	89,063	5.62%
Gross Funds	3,005,454	3,071,906	2.21%

Local fund increase is the net of savings in provider payments, and a technical adjustment for the change in federal Medicaid reimbursement for the childless adults.

Increase driven by higher anticipated revenue for Healthy DC ($12.1M). This increase was slightly offset by a lower budgeted amount for the Nursing Home Quality of Care fund.

Health Care Bill of Rights Assessment increased to capture entire District funded cost of the DHCF Ombudsman program. TPL budget higher in FY17 based on FY15 revenue collected.

Federal grant funding has a net increase of $1.9 million or 191.61% in FY 17. Two new grants, Money Follows the Person and Mobile Technology and Integrated Care, are budgeted while the state innovation model (SIMM) grant is not budgeted in FY 17.

Federal Medicaid match to General Fund spending above.

This category reflects the local share that is supported by Other District agencies. Intra-District agreements for the DD Waiver and MHRS programs.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

PROPOSED FY 17 BUDGET

Pathways to the Middle Class
Mayor Muriel Bowser

FY16 Budget $700,010,624

FY17 Current Service Funding Level $713,584,166

The CSFL increased by 1.9% from FY16

- Pay raises and adjustments of $396,645
- $554,221 increase in Consumer Price Index
- $108,816 increase in Fixed Cost Inflation
- $10,613,860 increase in Medicaid provider payments
- $1,900,000 increase in Operating Impact of Capital

FY17 Budget Adjustments -$7,163,178

The net effect of 3 changes

- $22,275,256 reduction for provider payment savings
- $592,325 increase in contracts cost beyond the CSFL
- $14,519,753 increase for federal reimbursement shift for Childless Adults from 100% to 95% effective January 1, 2017 – this was a Technical Adjustment

FY17 DHCF Local Proposed Budget
$ 706,420,988

Medicaid Provider Payments	• **Increase of $54 million** • Significant increase in the Dedicated Taxes and Intra-District budget estimates
Public Provider Payments	• **Increase of $2.2 million** • Revision of budget estimates for CFSA & St. Elizabeth's Hospital
Alliance Provider Payments	• **Increase of $6.8 million** • Significant increase in the MCO rates

Medicaid Mandatory Services

(in Millions)

Medicaid Mandatory Service	FY15 Expenditures	FY16 Budgeted Amount	FY17 Budget Request
Inpatient Hospital	246.81	265.80	250.78
Nursing Facilities	236.91	303.51	283.67
Physician Services	35.55	45.51	39.46
Outpatient Hospital, Supplemental & Emergency	41.87	70.55	65.73
Durable Medical Equip (including prosthetics, orthotics, and supplies)	21.70	24.38	25.08
Non-Emergency Transportation	14.10	21.45	26.16
Federally Qualified Health Centers	50.81	21.98	55.71
Lab & X-Ray	13.50	13.32	13.18

Budget and spending information is based on SOAR which includes all adjustments. Data presented in subsequent slides is based exclusively on MMIS claims and may not include adjustments occurring at the provider level (FTs) or adjustments in SOAR.

Medicaid Optional Services

(in Millions) Medicaid Optional Services	FY15 Expenditures	FY16 Budgeted Amount	FY17 Budget Request
Managed Care Services	1,030.56	1,117.61	1,215.97
DD Waiver (FY 2015 includes intra-district funds from DDS)	184.02	199.33	206.95
Personal Care Aide	176.09	191.81	195.6
EPD Waiver	36.72	73.65	75.18
Pharmacy (net of rebates)	32.21	36.93	28.77
Mental Health (includes DBH intra-district for MHRS)	108.7	98.56	89.6
Day Treatment / Adult Day Health	7.14	13.57	13.27
Home Health	12.16	17.24	18.39

$9.9 mil	• **Fund Shift:** Shift expenses from local to dedicated tax
$1.5 mil	• **Capture Living Wage Savings :** Reduce rate increases driven by the Living Wage based on January 2016 increase of 0.3%.
$7.2 mil	• **Alter Payment Processing For FQHCs:** Shift processing of wrap payment for Federally Qualified Health Centers (FQHCs) from Managed Care Organizations (MCOs) to claims processor
$1.8 mil	• **Curtail Inflation Adjustments:** Eliminate inflations for institutional providers – nursing homes and ICF/IIDs
$1.5 mil	• **Insurance Tax Moratorium:** Moratorium on premium tax levied on health insurance plans from Feds
$0.3 mil	• **Updated Utilization Projections:** Net effect of updated utilization projections for all provider-types since the CSFL

$22.3 million

Key Facts Regarding Living Wage Initiative

- The proposed budget reduction for the FY2016 Living Wage does not eliminate the planned rate increase to account for the FY2017 Living Wage
  - DHCF adjusted the estimate of the cost for the FY2016 Living Wage in FY2017 based on the actual increase experienced in FY2016
  - If the actual increase in the Living Wage is determined to be higher than expected, DHCF will look for savings from other service lines to cover the gap

Key Facts Regarding Inflation Adjustment Savings

- While the proposed inflation adjustment alters plans to pay nursing homes and ICF/IIDs a separate add-on to their rates for inflation, any required Living Wage increase is unaffected
  - The full Living Wage increase that is mandated in January of each year will still be paid

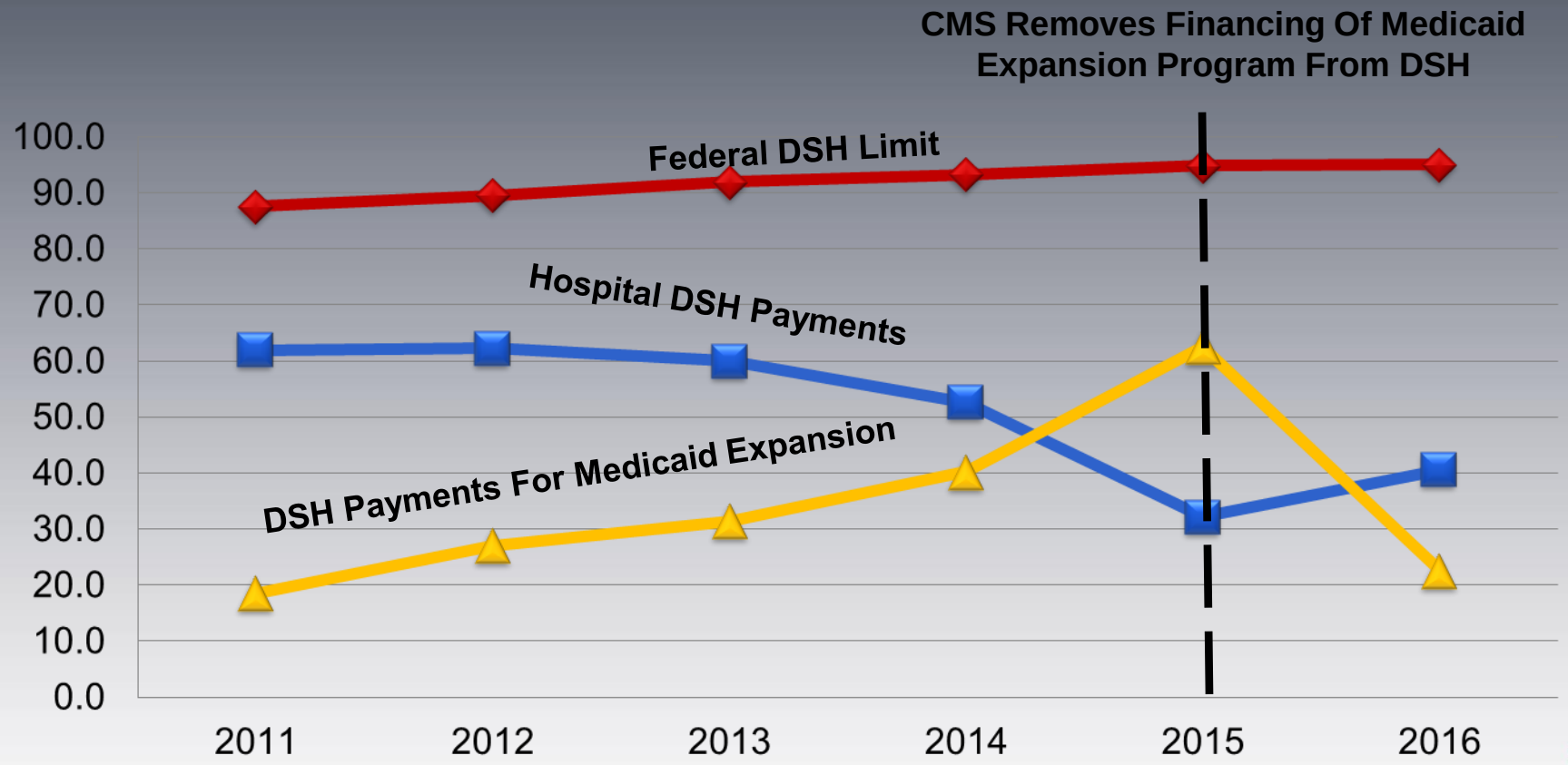
Why Did DHCF Request Only $3 Million To Draw Down $10 Million In Disproportionate Share Hospital (DSH) Payments For Private Hospitals?

- The District's federal DSH limit is more than $95 million – this requires a local match of nearly $29 million

- However, an expected reduction in the level of uncompensated care that hospitals will experience in FY2017 obviates the need for a large draw down of DSH funding. Key factors are:

  - High level of insurance coverage in the District
  - Robust Medicaid fee-for-service payment rates for hospitals
  - Comparably robust MCO payment rates for hospitals

DSH Payments For Medicaid Expansion Reduce Payments To Hospitals



Note: From December 2010 to December 2015, the federal portion of the funds used to cover the cost of the Medicaid Expansion population were drawn from the DSH fund through a CMS Waiver. In December 2015 the Waiver expired and CMS approved the use of State Plan funds to pay for Medicaid Expansion..

Hospital Inpatient Medicaid Payments Are Near Cost

Hospital	Total Charges	Total Cost	Total Paid	Payment To Cost Ratio
Children's National	$38,370,642	$13,427,866	$15,558,644	116%
George Washington Hospital	$131,306,225	$31,285,350	$34,820,002	111%
Georgetown University Hospital	$70,906,347	$20,845,476	$18,718,971	90%
Howard University Hospital	$82,323,681	$48,820,708	$40,438,564	83%
Providence Hospital	$45,272,890	$19,330,309	$23,205,286	120%
Sibley Memorial Hospital	$5,159,265	$2,352,982	$1,985,035	84%
United Medical Center	$36,560,375	$16,850,309	$16,520,221	98%
Washington Hospital Center	$218,202,456	$63,957,933	$59,861,889	98%
National Rehab. Hospital	$7,681,930	$4,653,713	$4,200,075	94%
Psychiatric Institute of Washington	$2,663,299	$1,630,205	$1,865,337	114%
DCA Capitol Hill LTACH	$9,882,676	$3,392,723	$4,825,868	142%
DCA Hadley LTACH	$11,419,915	$3,834,807	$7,245,715	189%
HSC Pediatric Center	$6,018,843	$4,284,212	$3,708,679	87%
Total	$665,768,544	$234,666,593	$232,954,286	99.3%

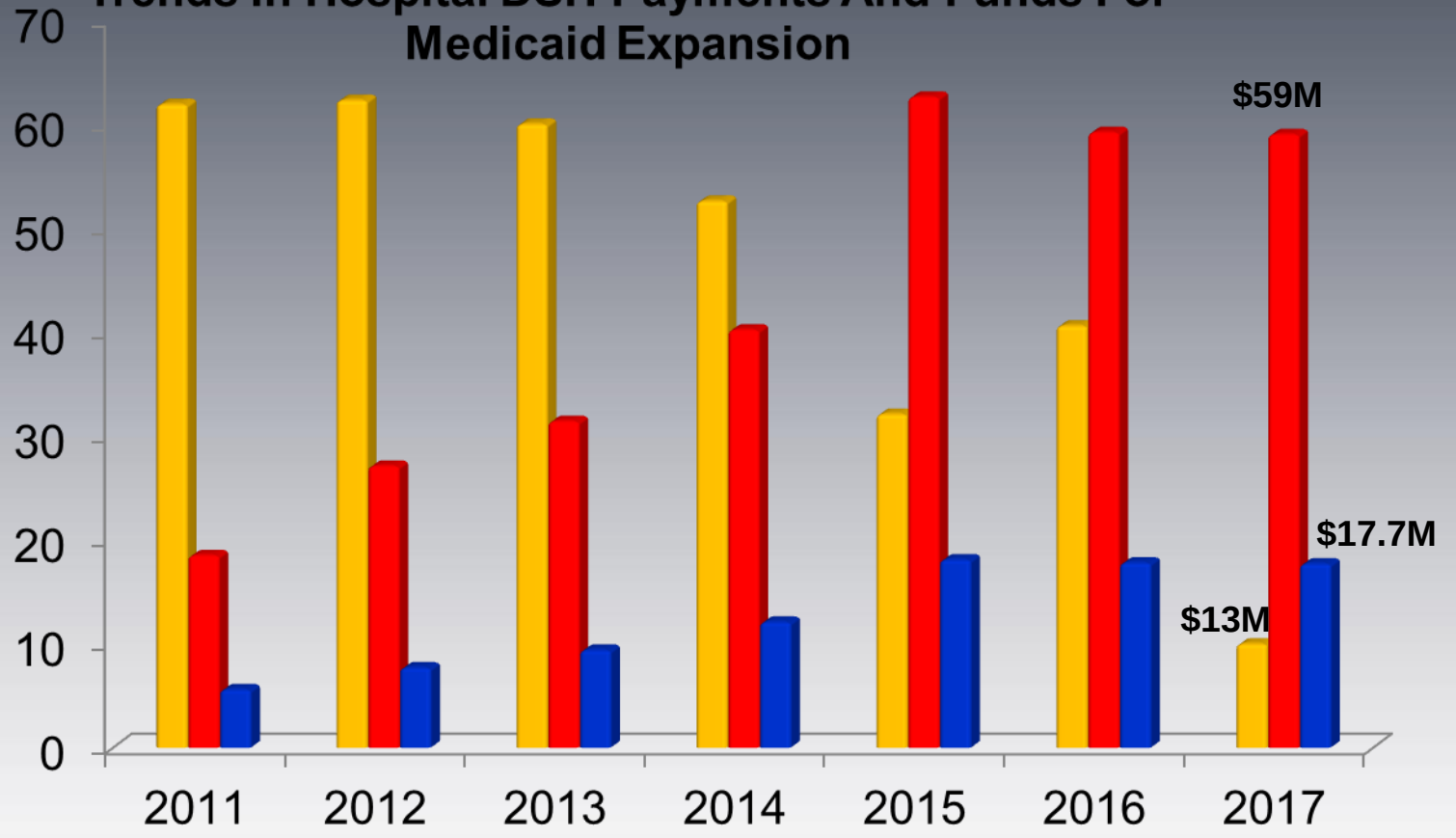
Notes: Cost is based on FY15 cost report factors applied to year-to-date FY 2015 claims, assuming 94% completion through October 19, 2015 for DRG hospitals and 90% for Specialty hospitals. Costs are estimated using preliminary FY 2015 Cost-to-Charge Ratios (CCR). DHCF estimated CCRs for Capitol Hill and Hadley.

Source: Xerox Consulting Services, March 2016.

Summary Of Factors Impacting The Need For DSH Funds Directed To Private Hospitals

- Factors Affecting DSH Need
  - FFS inpatient payments at 98% of cost
  - FFS outpatient payments at UPL
  - MCO inpatient payments comparable to FFS
  - MCO outpatient payments exceed FFS significantly
  - Virtually no uninsured District residents
  - FY 2011 DSH
    - $7.2M could not be redistributed after audit
    - FY 2011 was prior to outpatient rate increases and UPL payments

Trends In Hospital DSH Payments And Funds For Medicaid Expansion



Note: From December 2010 to December 2015, the federal portion of the funds used to cover the cost of the Medicaid Expansion population were drawn from the DSH fund. These numbers include local dollars that were used to draw down federal DSH payments from December 2010 to December 2015. This figures also include Healthcare Alliance total of $5.6 million in FY 2011 and $1.4 million in FY 2012.

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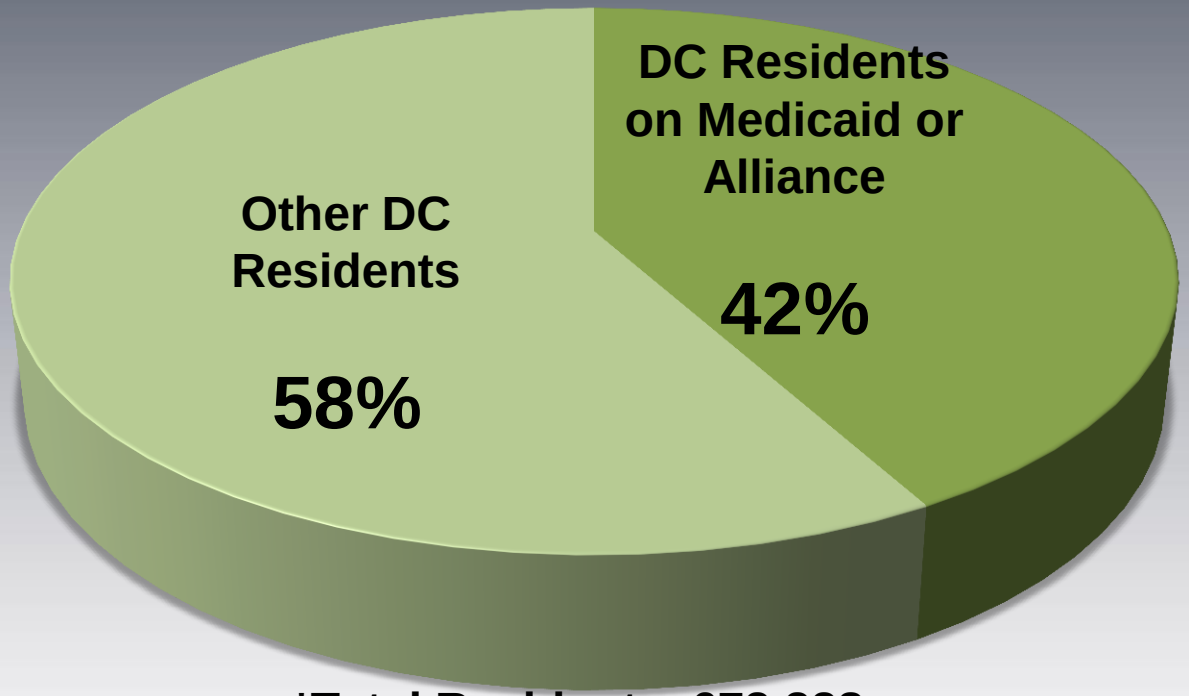
More Than Four In 10 District Residents Are Either Enrolled In Medicaid Or The Alliance Program

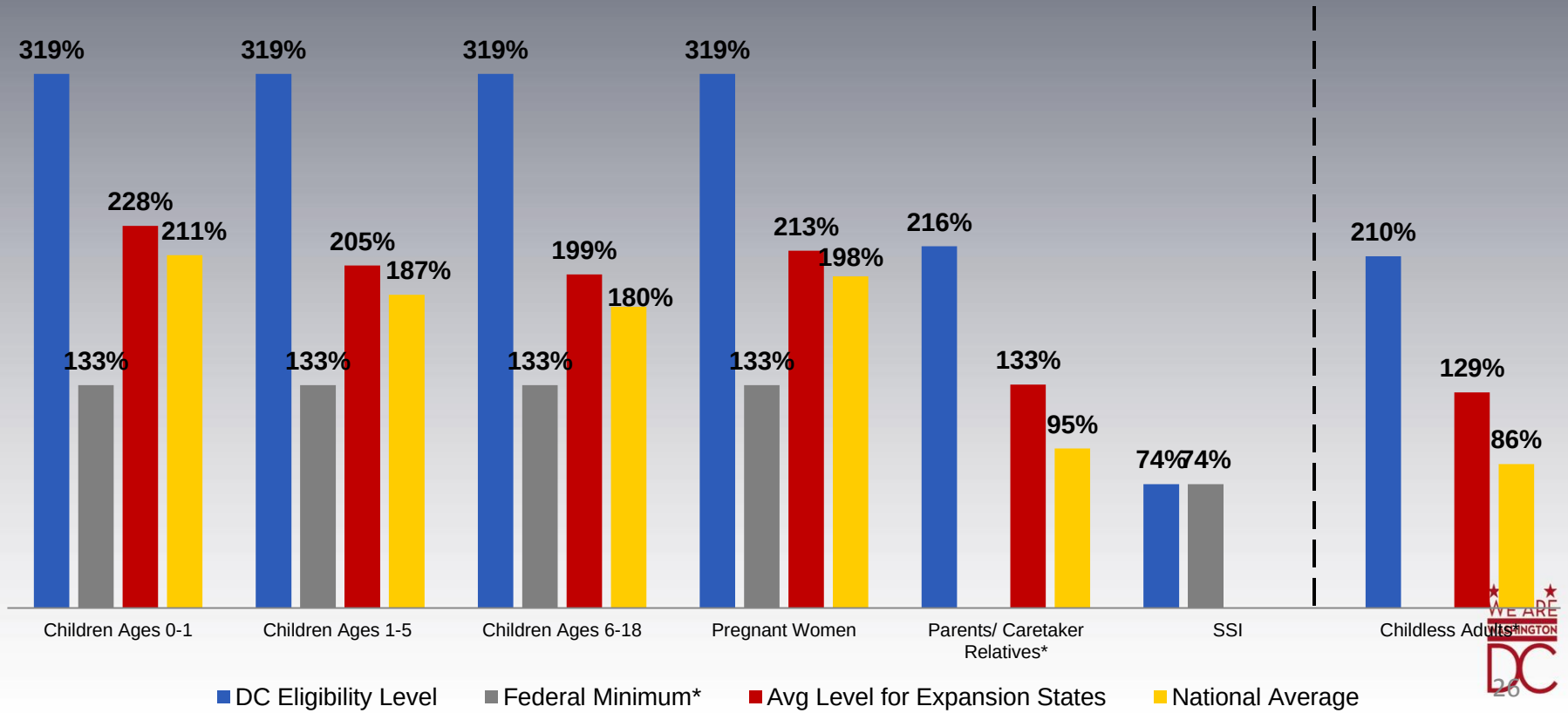


***Total Residents 672,228**

Source: District population estimate from United States Census Bureau. Medicaid and Alliance data reported from DHCF's Medicaid Management Information System (MMIS).

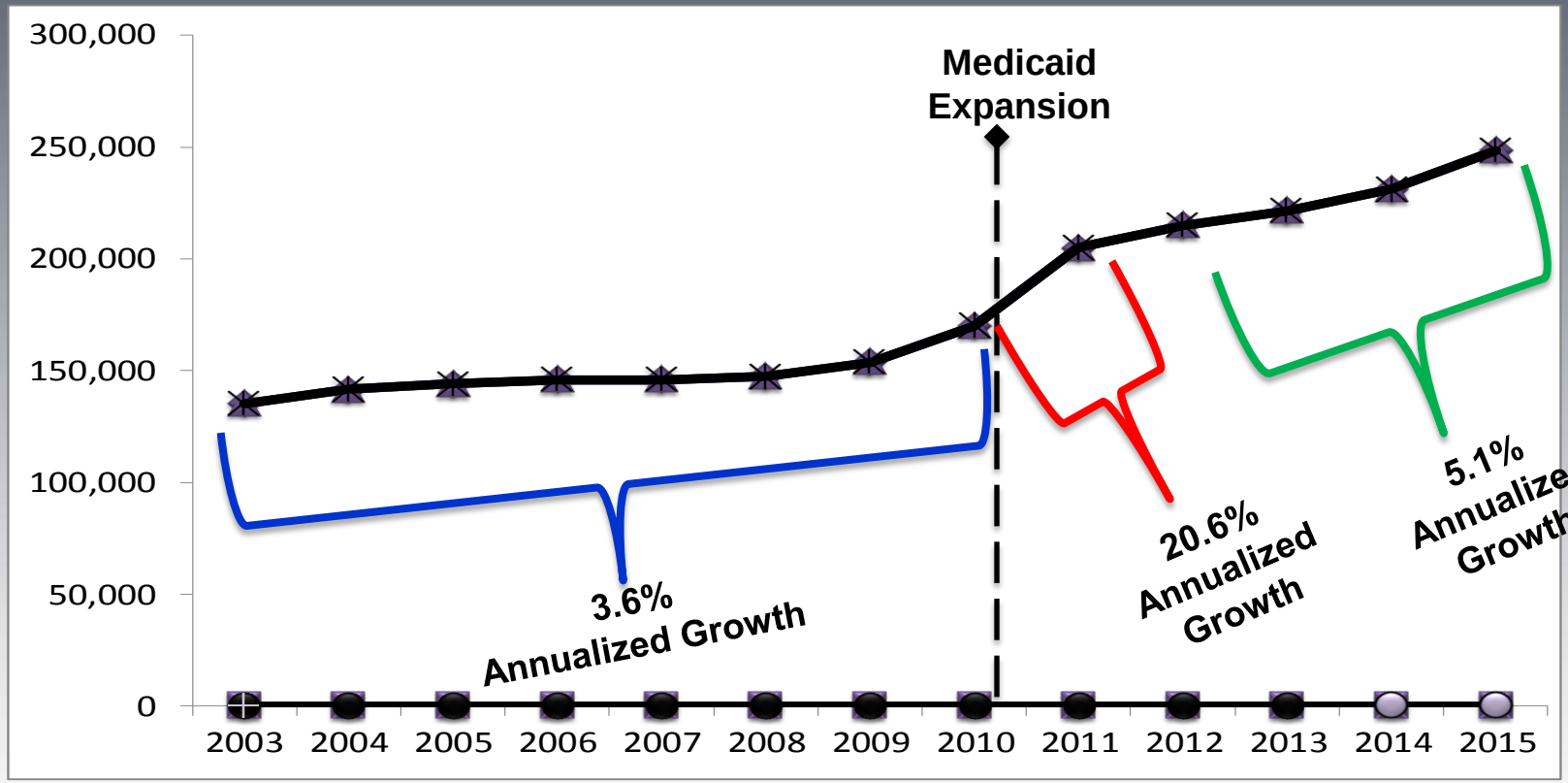
Note: These data exclude District residents who are not United States Citizens and thus the percent of residents on publicly funded health care may be slightly overstated..

The District Has Significantly Higher Medicaid Eligibility Thresholds Compared To Federal Requirements, The Experience In Other Expansion States And The National Average



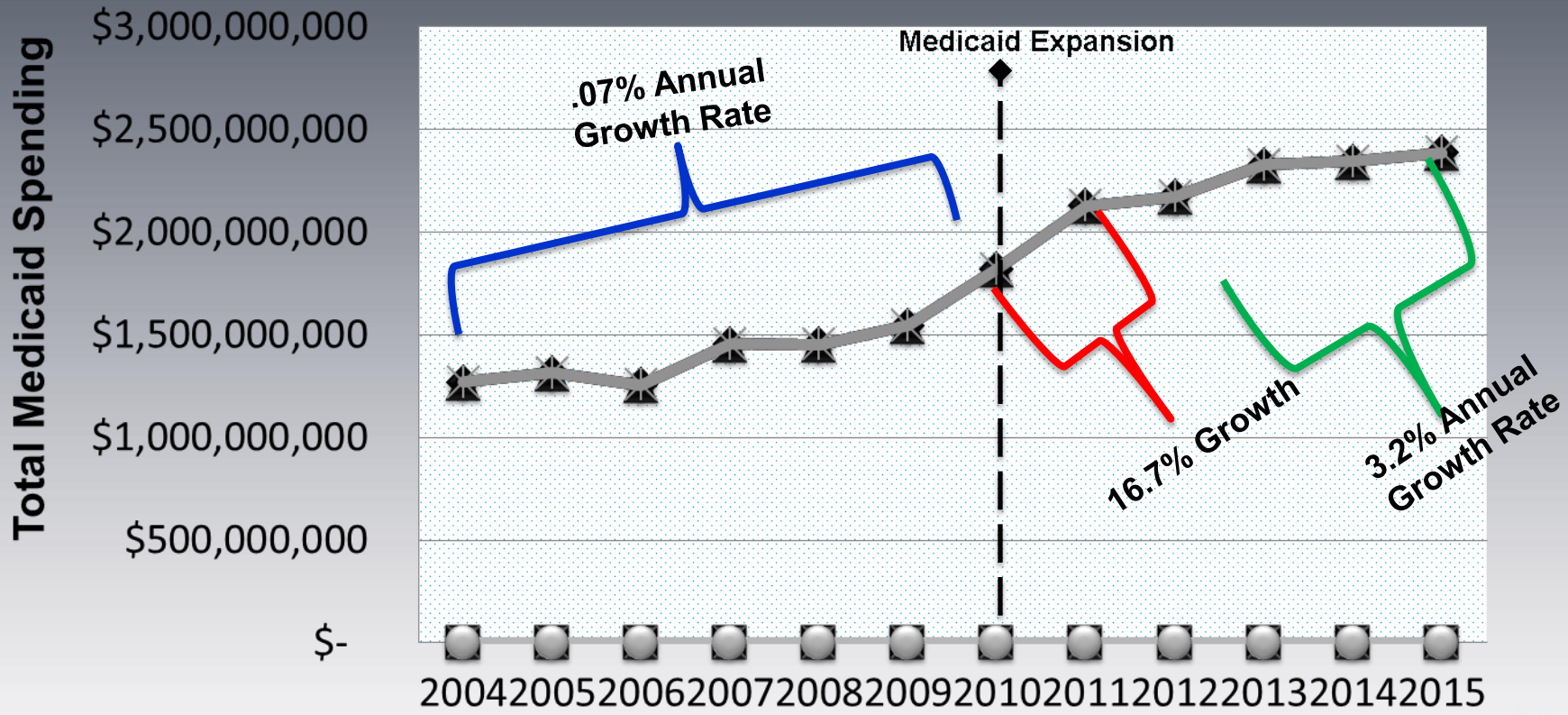
*There is no federal minimum for the parent or childless adult category and childless adults, is a federal option for states

The District's Medicaid Enrollment Growth Rates, Post-Expansion, Are Moderating But Remain Higher Than Pre-Expansion Rates



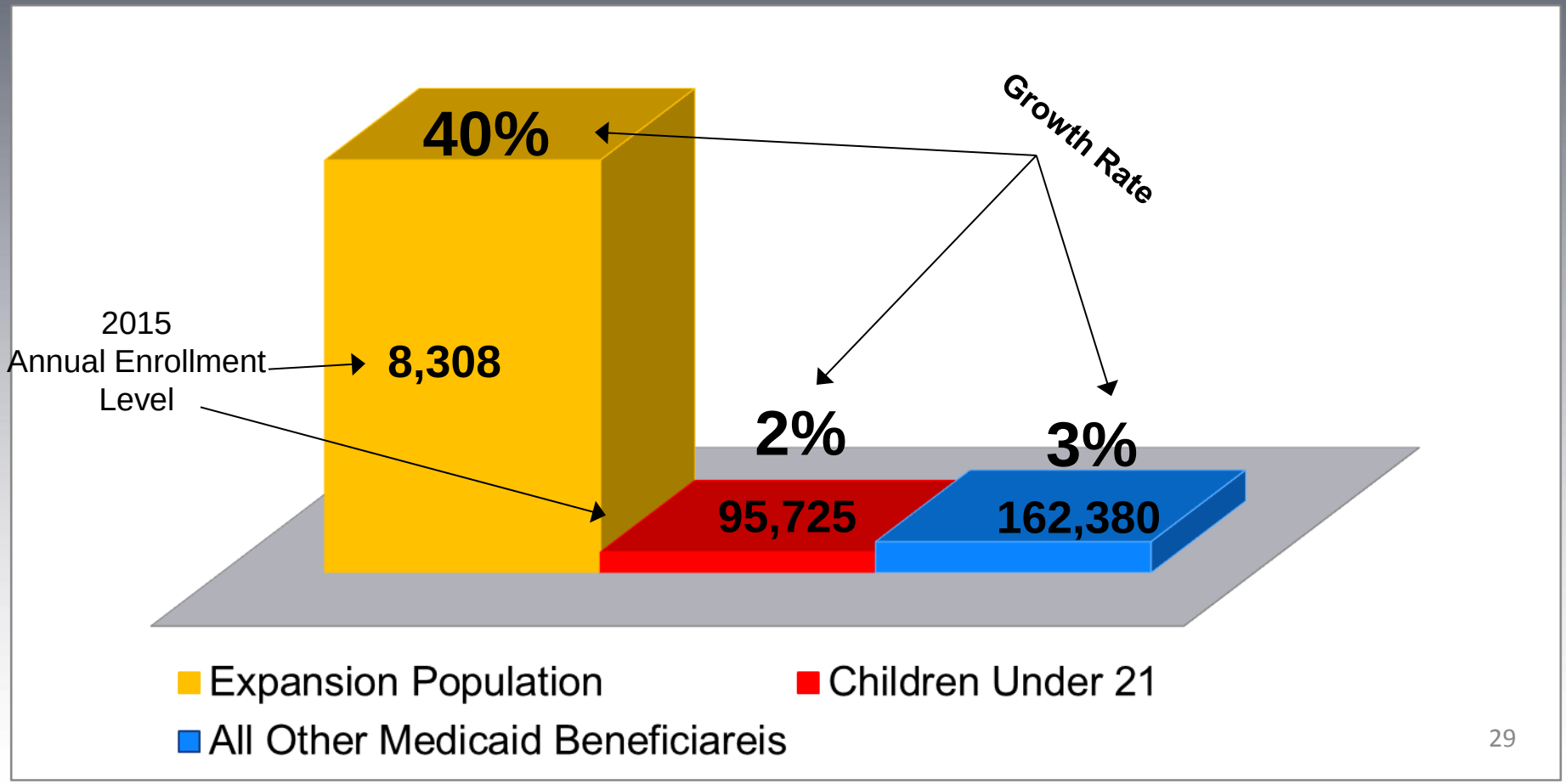
Sources and Notes: Excludes ineligible individuals (individuals who failed to recertify due to lack of follow-up, moving out of the District, excess income, or passed away), the Alliance, and immigrant children. Data for 2000-2009 data was extracted by Xerox from tape back-ups in January, 2010. Data from 2010-present are from enrollment reports

Annualized Growth In Medicaid Expenditures, FY2000-FY2015

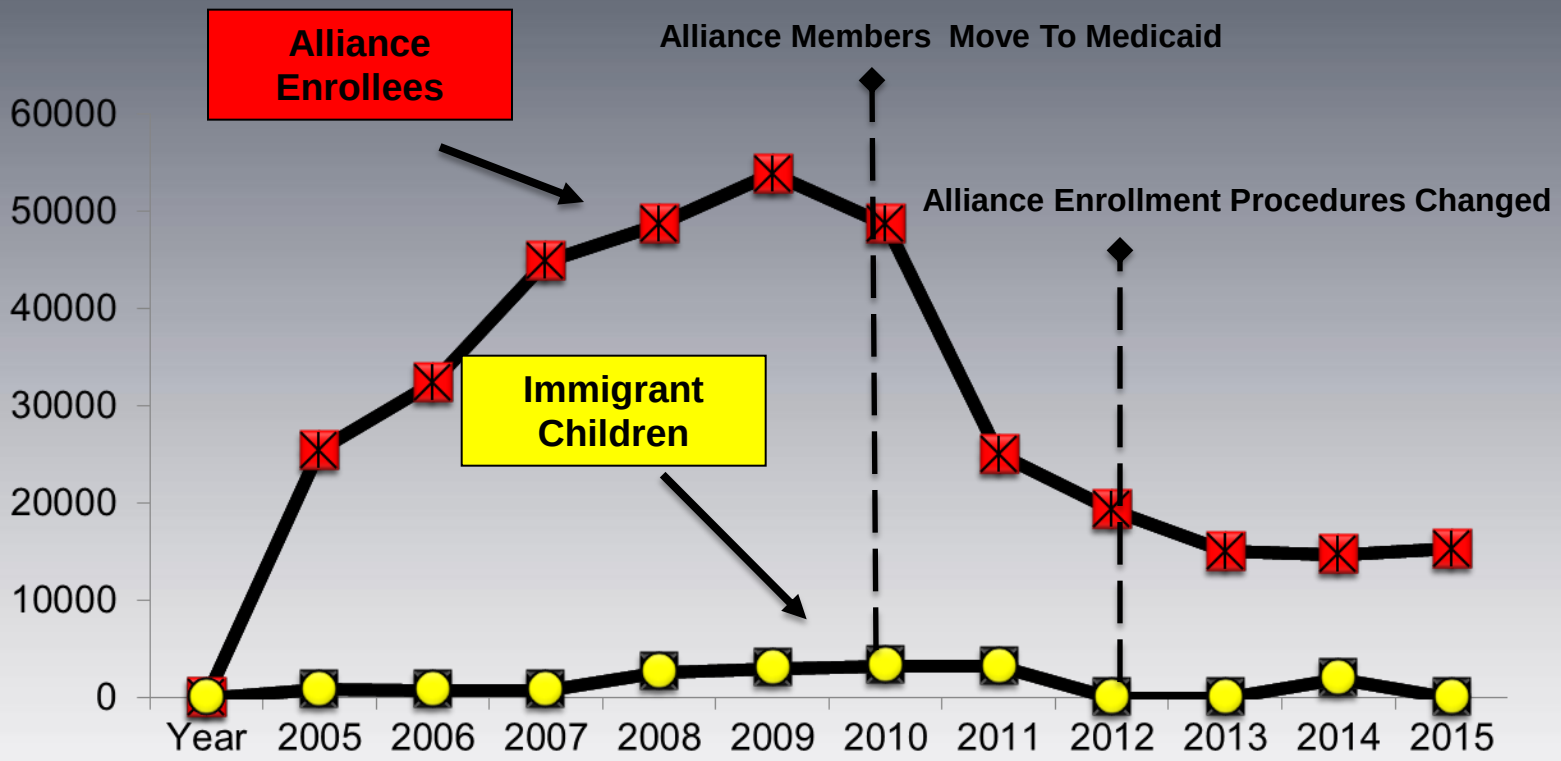


Source: FY08-FY11 totals extracted from Cognos by fiscal year (October, 1 through September, 30), using variable Clm Hdr Tot Pd Amt (total provider reimbursement for claim). Includes fee-for-service paid claims only, including adjustments to claims, and excludes claims with Alliance Line of Business or Immigrant Children's group program code. Only includes claims adjudicated through MMIS; excludes expenditures paid outside of MMIS (e.g. pharmacy rebates, Medicare Premiums).

Annualized Growth Rate For Expansion Population Is Substantially Higher Than Witnessed For Other Medicaid Groups

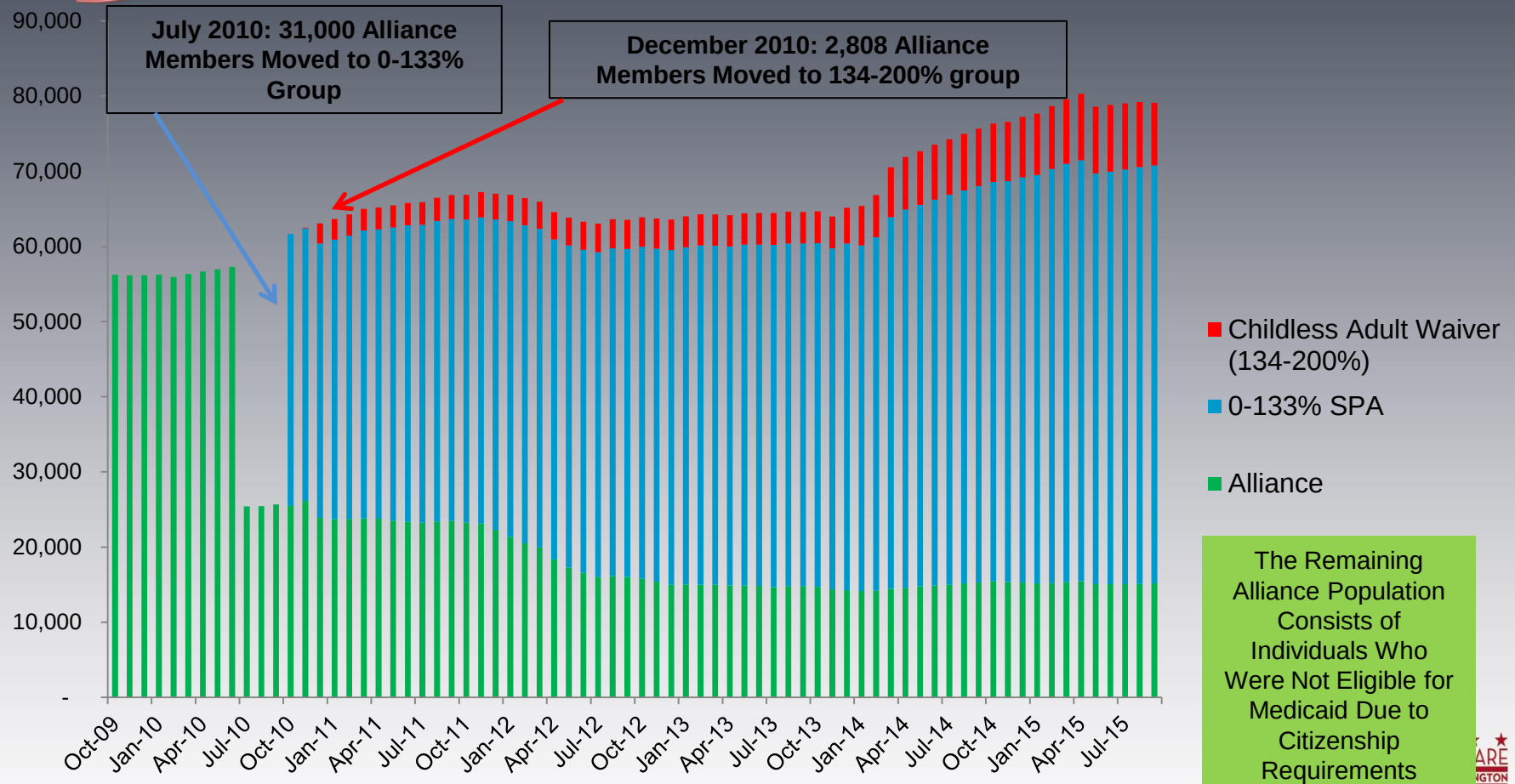


Enrollment Trends For Alliance Adult Population Is Moderating



Sources: Excludes ineligible individuals – persons who failed to recertify due to lack of follow-up, moving out of the District, or had excess income, or passed away. Data for 2000-2009 data was extracted by ACS from tape back-ups in January, 2010. Data from 2010-forward are from enrollment reports.

While Alliance Enrollment Has Dropped Over the Past Five Years, Many Members Continued Receiving Coverage Through Medicaid

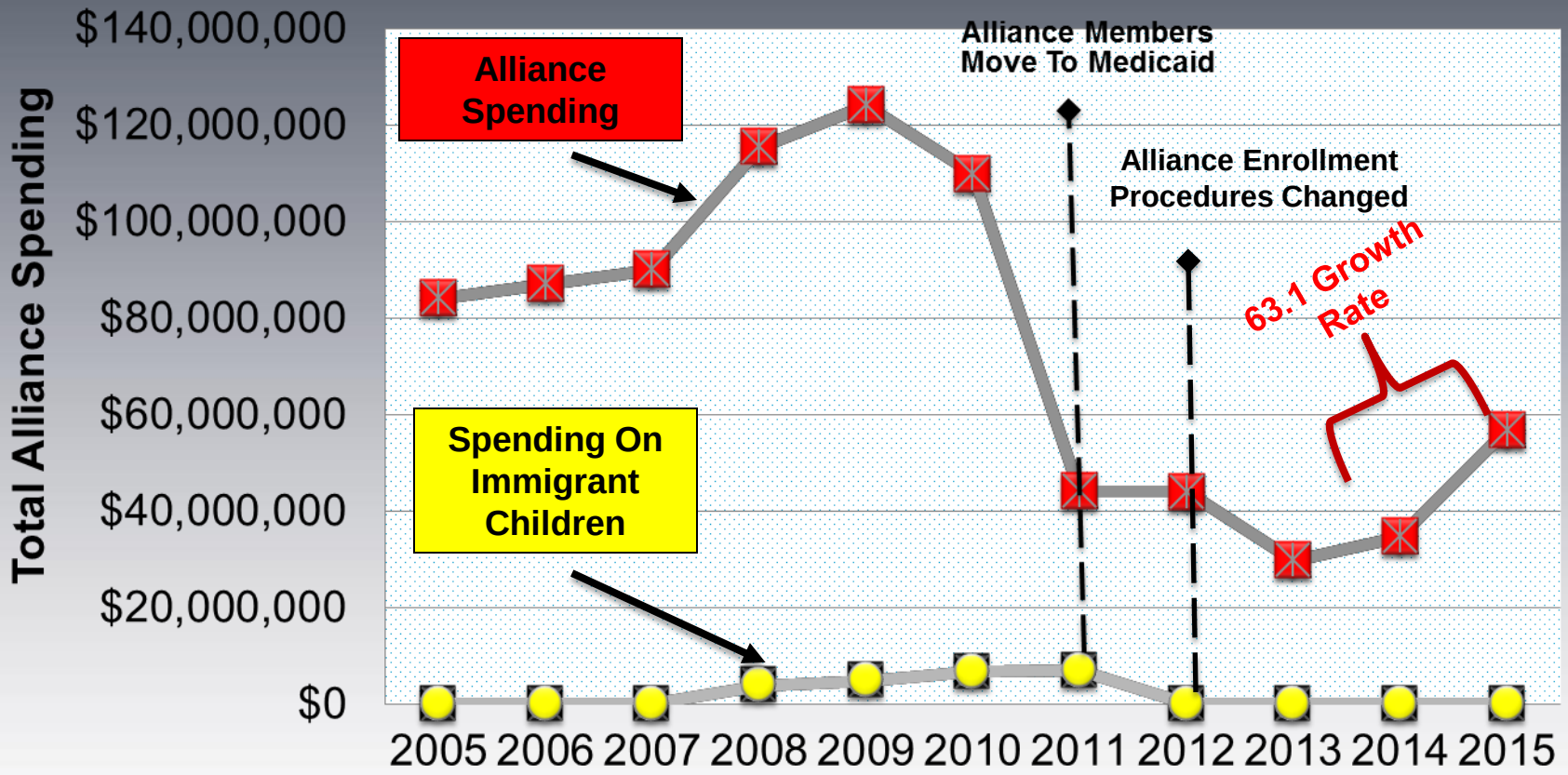


The Remaining Alliance Population Consists of Individuals Who Were Not Eligible for Medicaid Due to Citizenship Requirements

Source: historical enrollment numbers were compiled by the Division of Analytics and Policy Research.

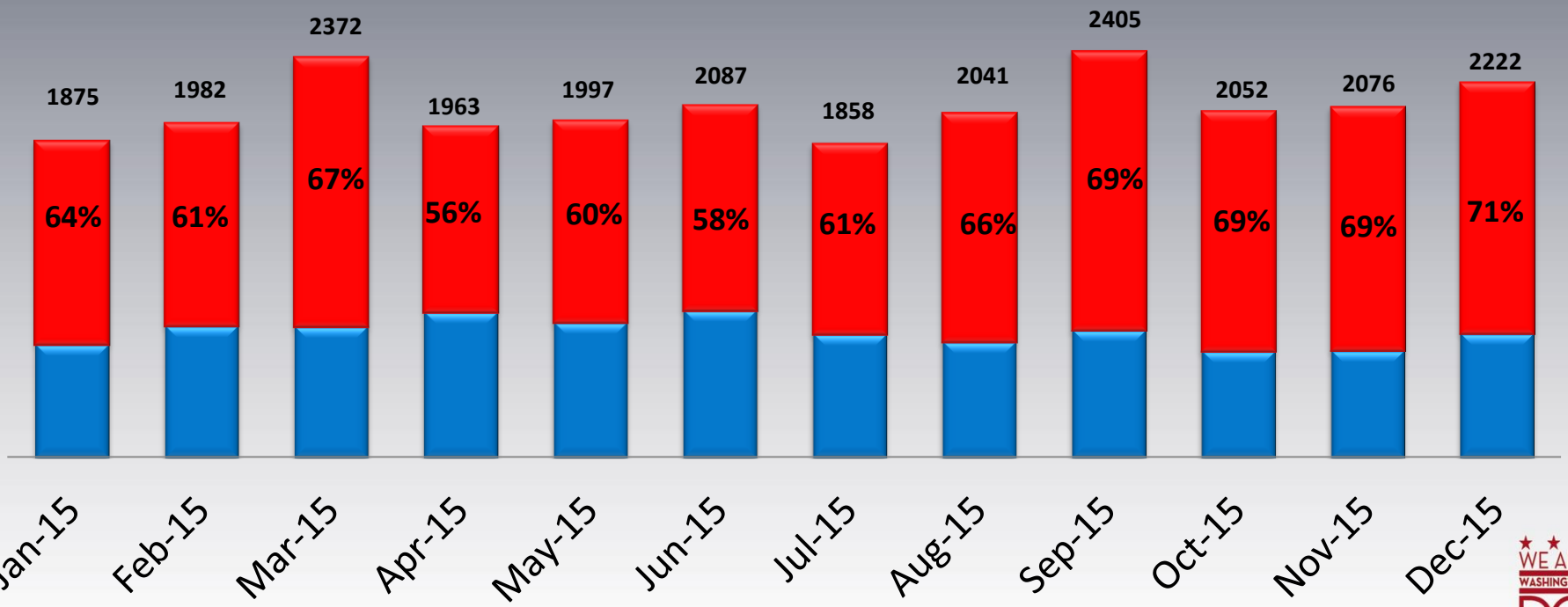
And Alliance Cost For Adults Are Spiking

Expenditure Trends For Alliance And Immigrant Children, 2005-2015

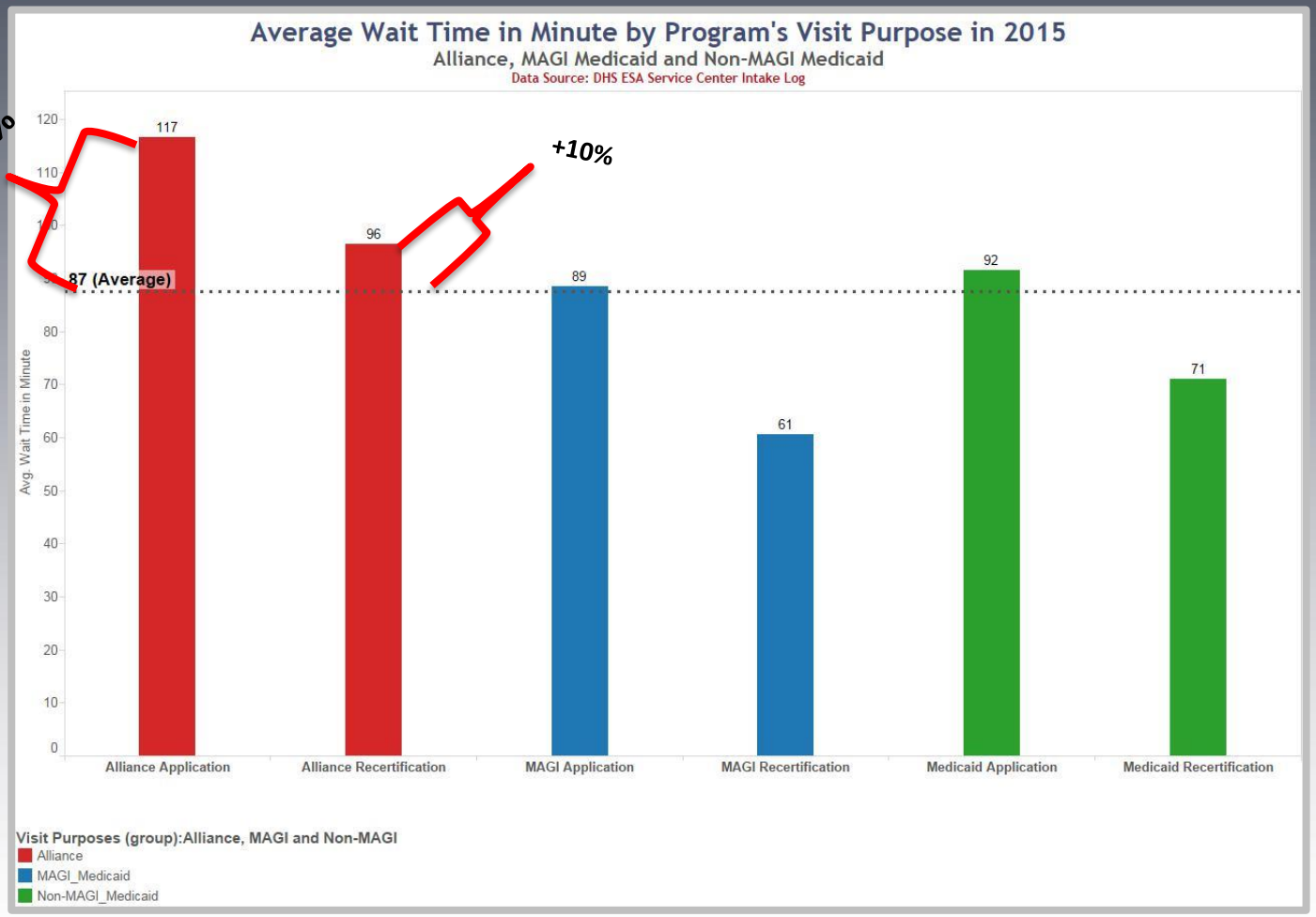


Source: FY08-FY11 totals extracted from Cognos by fiscal year (October, 1 through September, 30), using variable Clm Hdr Tot Pd Amt (total provider reimbursement for claim). Includes fee-for-service paid claims only, including adjustments to claims, and excludes claims with Alliance Line of Business or Immigrant Children's group program code. Only includes claims adjudicated through MMIS.

Most Alliance Applicants Are Terminating The Recertification Process Before Completion



Longer Wait Times For Alliance Applications And Recertifications Are Potentially A Problem



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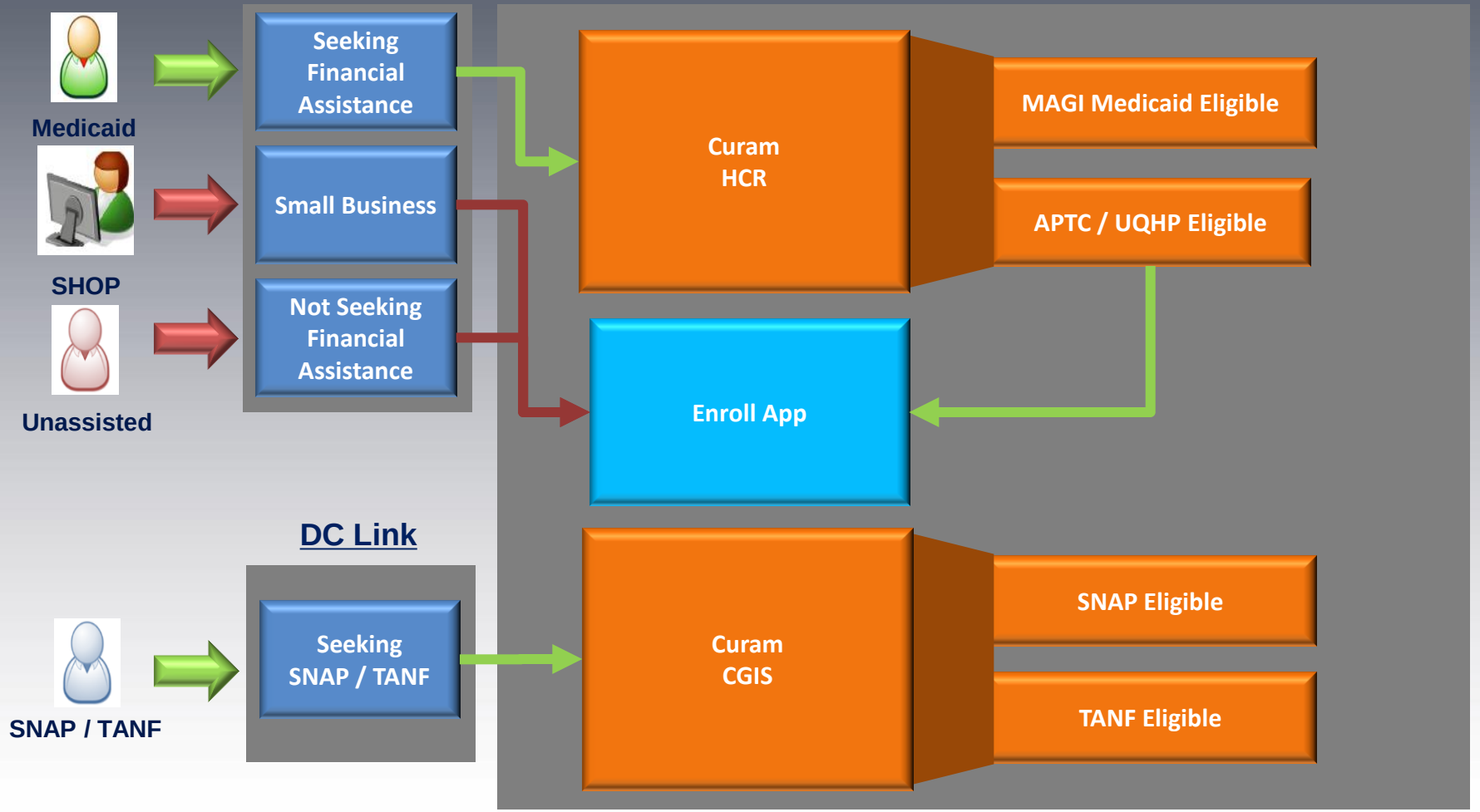
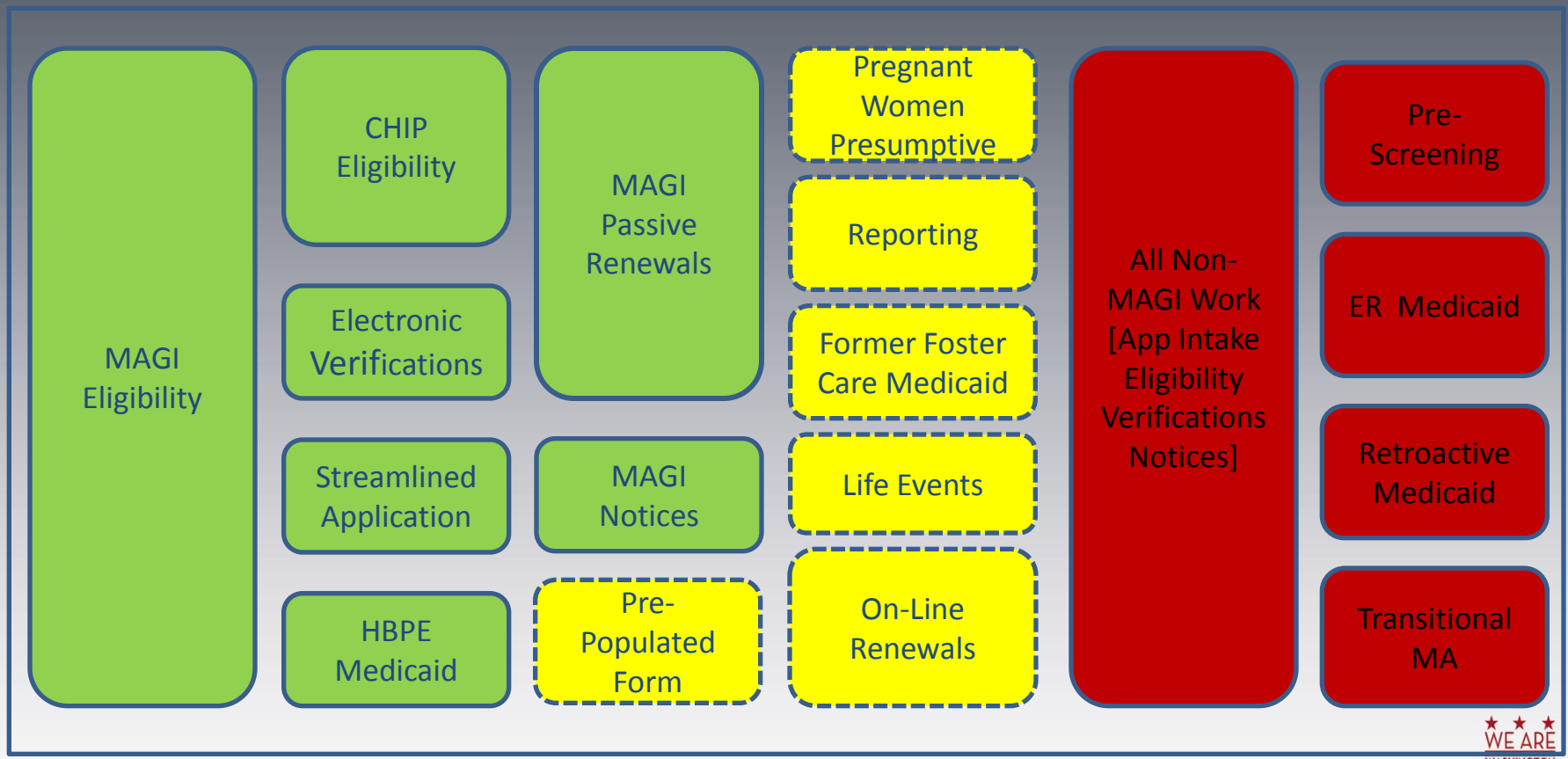
High Level Overview of the DCAS System in FY 2017



Current Functionality For Automated Medicaid System As Of April 2016 Is Limited

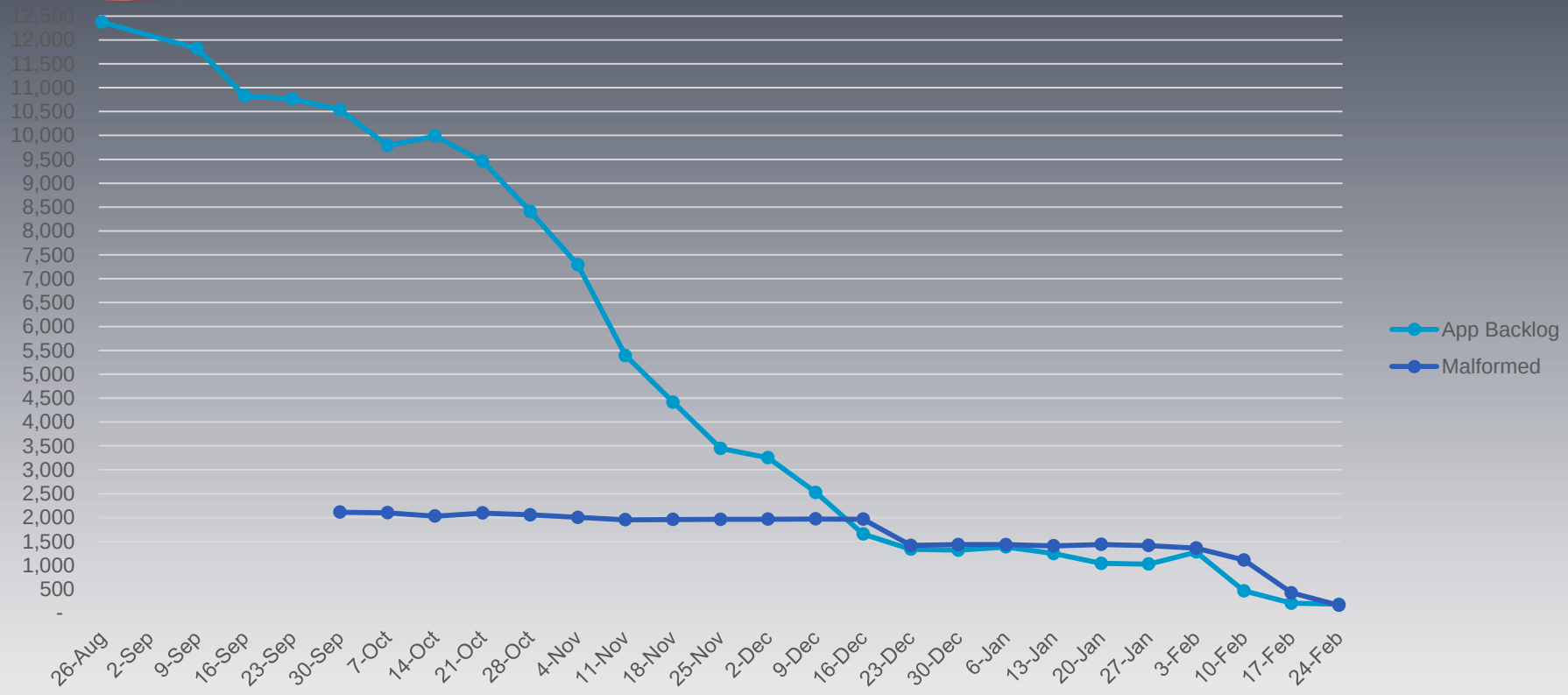


Functionality Exists

Partially Automated or in Process

Functionality Planned for Release 3

However Considerable Progress Has Been Made On Clearing Backlogs in FY 2016 Due To System Defects

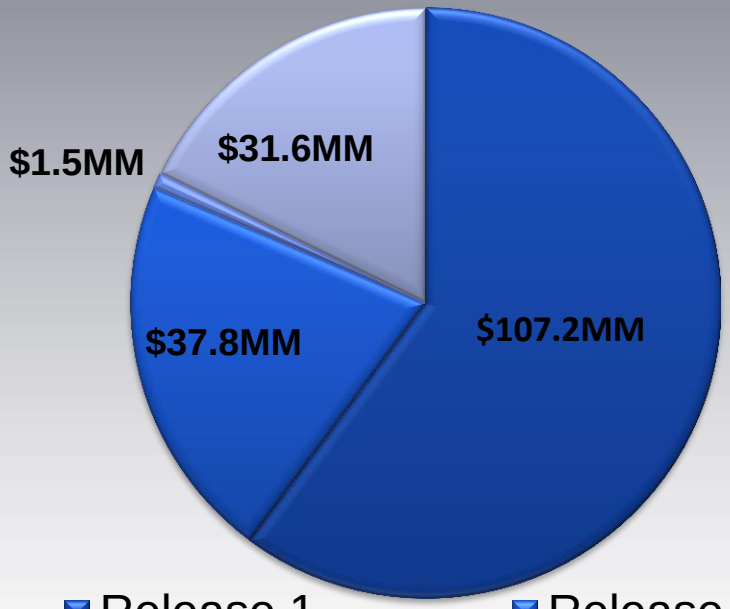


	26-Aug	9-Sep	16-Sep	23-Sep	30-Sep	7-Oct	14-Oct	21-Oct	28-Oct	4-Nov	11-Nov	18-Nov	25-Nov	2-Dec	9-Dec	16-Dec	23-Dec	30-Dec	6-Jan	13-Jan	20-Jan	27-Jan	3-Feb	10-Feb	17-Feb	24-Feb
Malformed					2,112	2,101	2,029	2,095	2,057	2,003	1,953	1,958	1,963	1,965	1,970	1,965	1,417	1,432	1,432	1,408	1,437	1,414	1,359	1,110	422	162
App Backlog	12,371	11,821	10,825	10,763	10,535	9,791	9,986	9,459	8,409	7,292	5,390	4,416	3,448	3,250	2,527	1,653	1,337	1,316	1,385	1,247	1,041	1,026	1,279	465	205	184

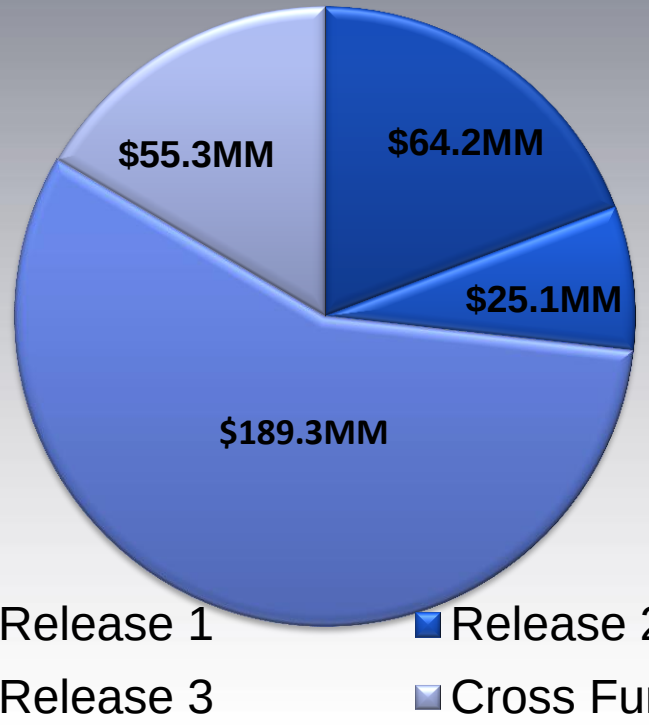
An Additional $334.0 Million Will Be Needed To Complete Work On The DCAS Eligibility System

Total Past And Projected Spending For DCAS, by Release

By Release - Past
Total $178,205,556



By Release - Future
Total $334,070,574



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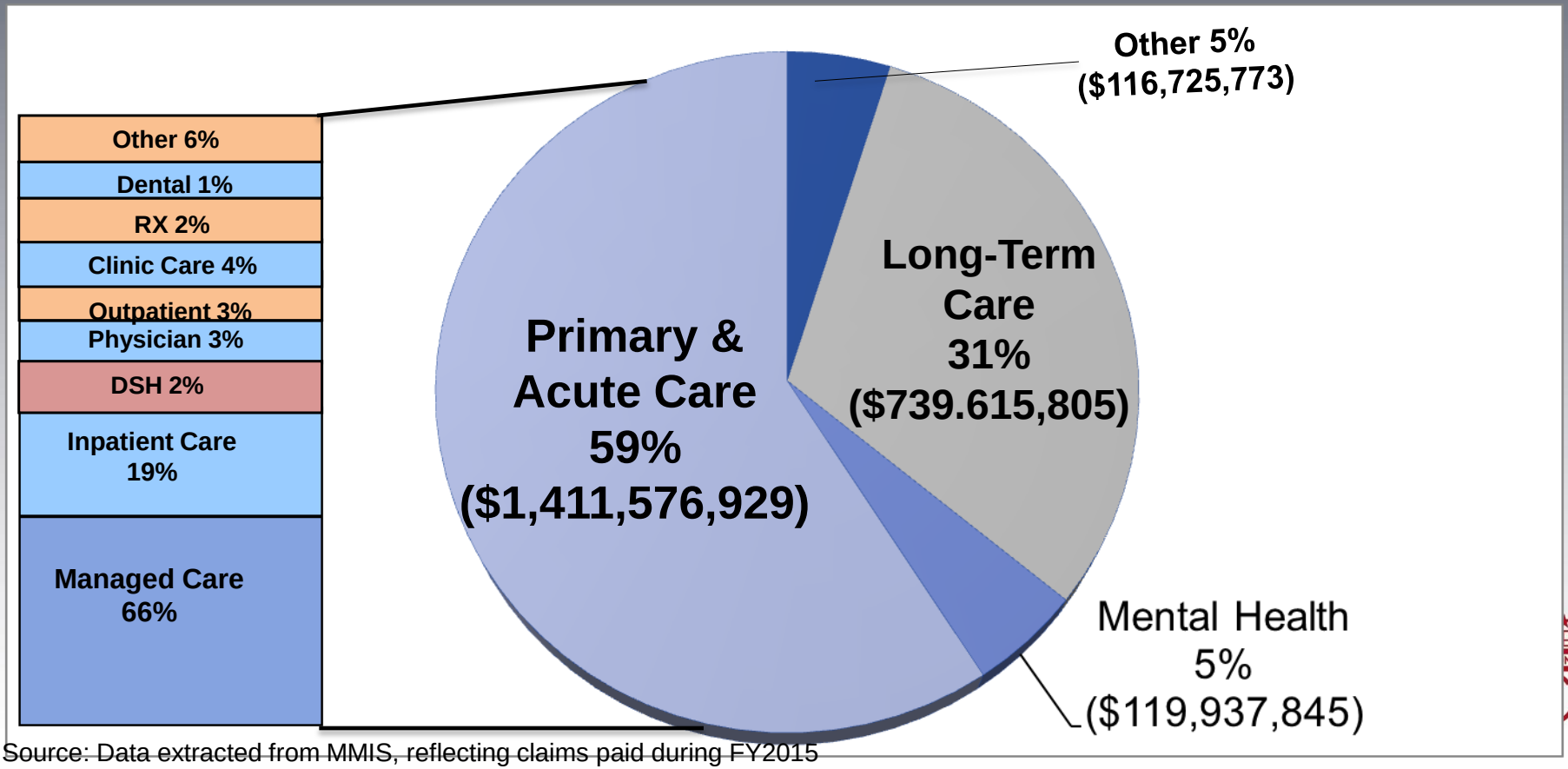
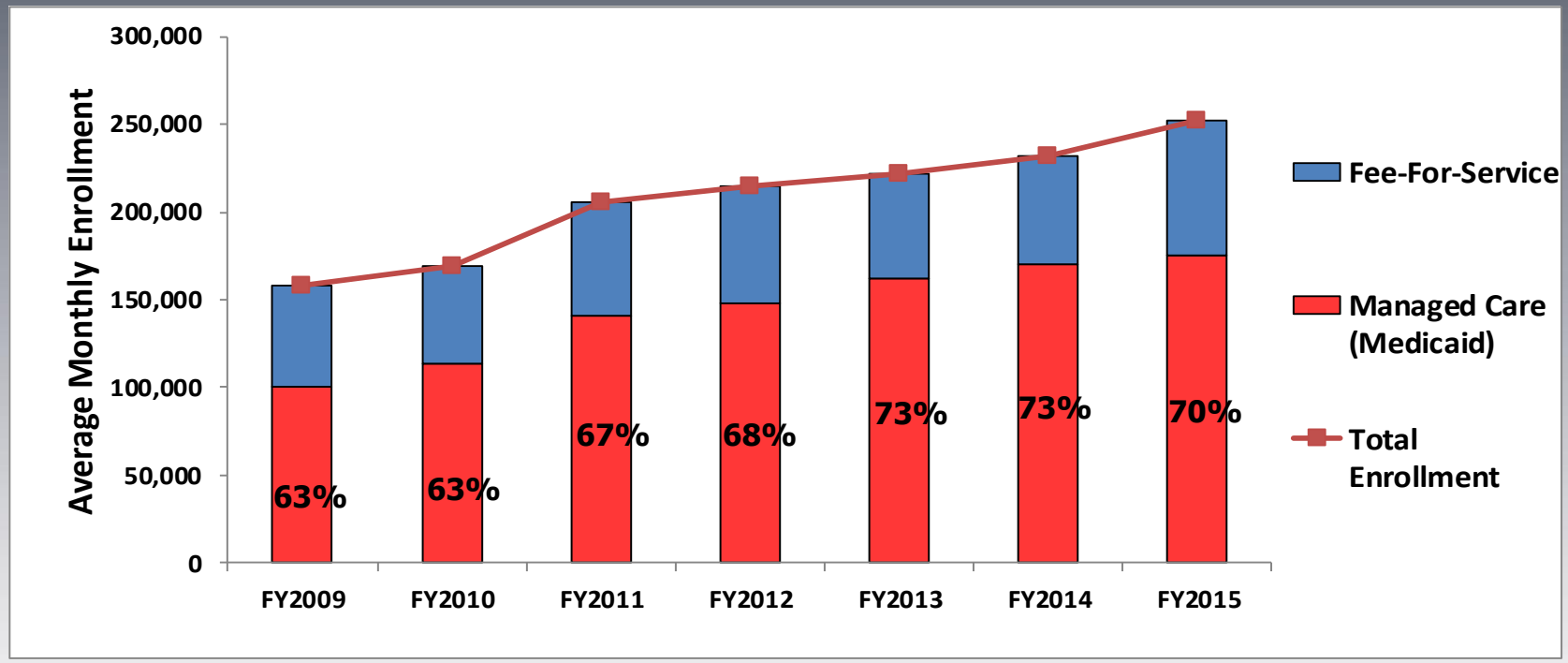
Acute Care Services Account For Nearly Six Of Every 10 Medicaid Dollars Spent

$2,387,856,353



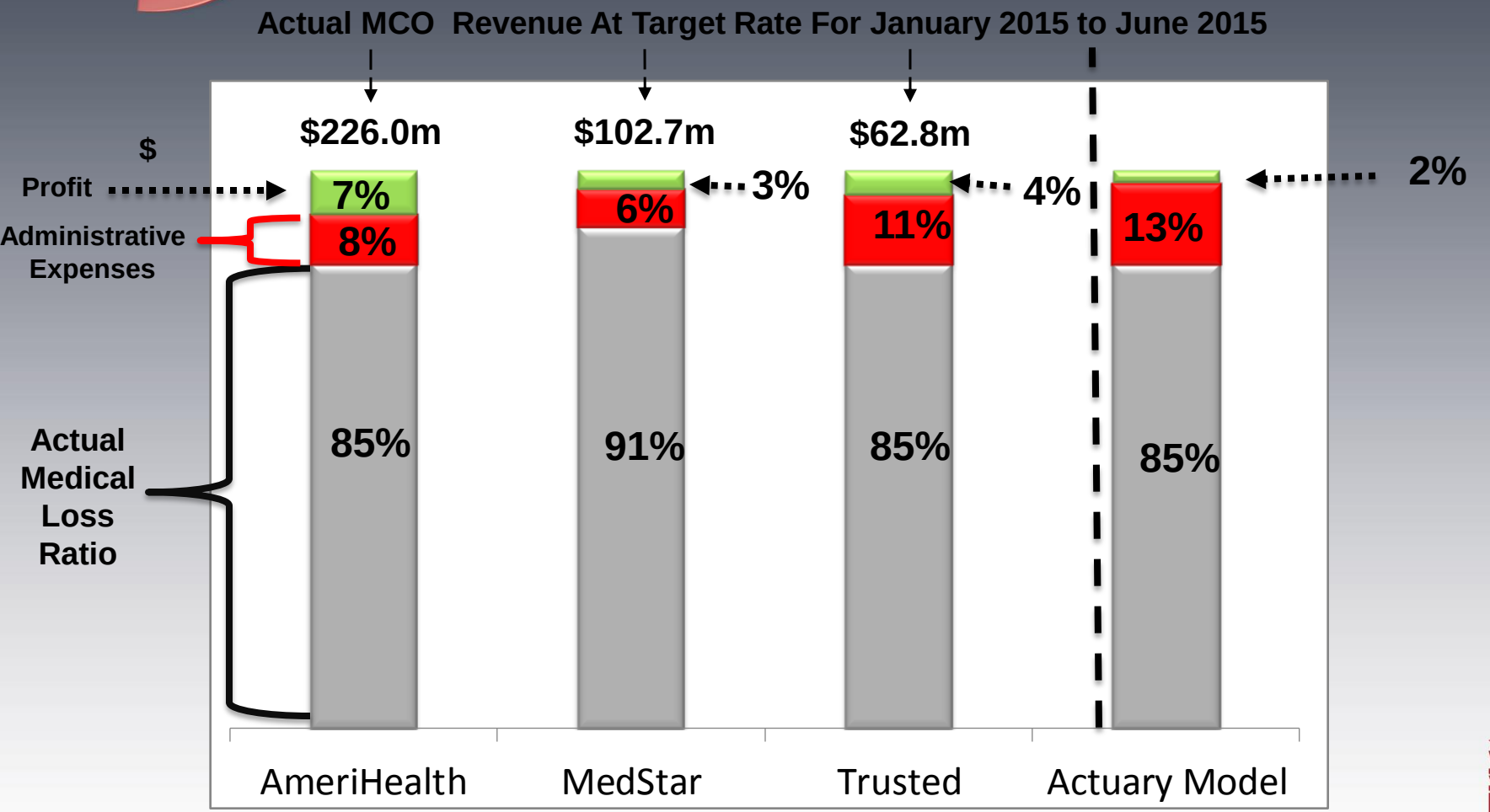
Source: Data extracted from MMIS, reflecting claims paid during FY2015

Seven Of Every 10 Medicaid Enrollees Are In The Managed Care Program



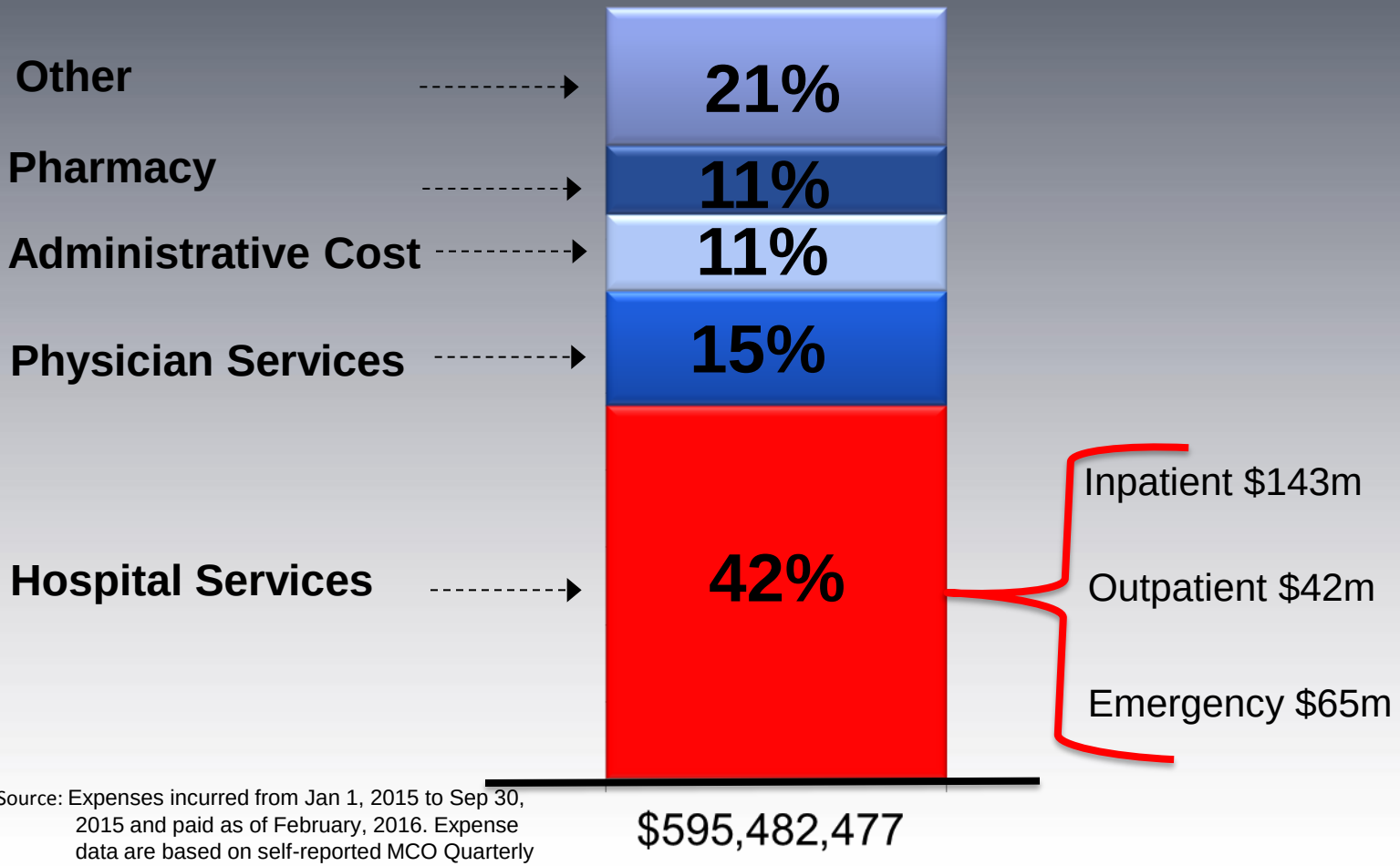
Source: DHCF staff analysis of data extracted from the agency's MMIS.

All Three Health Plans Meet Medical Expenditure Requirements



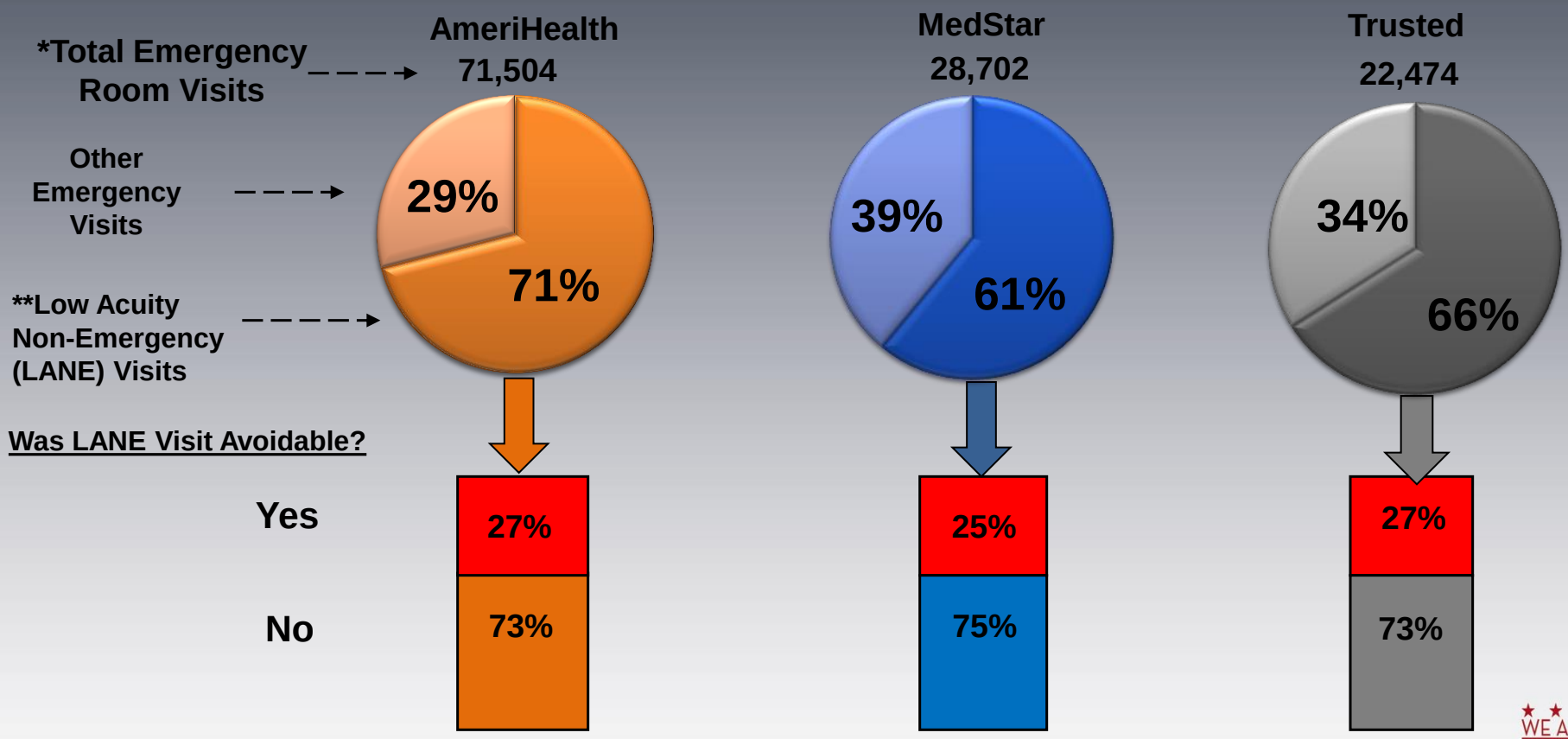
Notes: MCO revenue does not include investment income, HIPF payments, and DC Exchange/Premium tax revenue. Administrative expenses include all claims adjustment expenses as reported in quarterly DISB filings, excluding cost containment expenses, HIPF payments and DC Exchange/Premium taxes.
Source: MCO Quarterly Statement filed by the health plans with the Department of Insurance, Securities, and Banking.

Managed Care Medicaid Expenses, January 2015 – September 2015



Source: Expenses incurred from Jan 1, 2015 to Sep 30, 2015 and paid as of February, 2016. Expense data are based on self-reported MCO Quarterly Financial Data submitted to DHCF.

Use Of ER For Low Acuity Conditions Remains Problematic



*Total emergency department visits consists of all visits to the emergency room regardless of diagnosis which did not result in an inpatient admission. **Low acuity non-emergency (Lane) visits are emergency room visits that could have been avoided based on a list of diagnosis applied to outpatient data. Practicing ED physicians and Mercer clinical staff reviewed each LANE code and assigned a target utilization percentage of visits that a highly efficient managed care plan could prevent.

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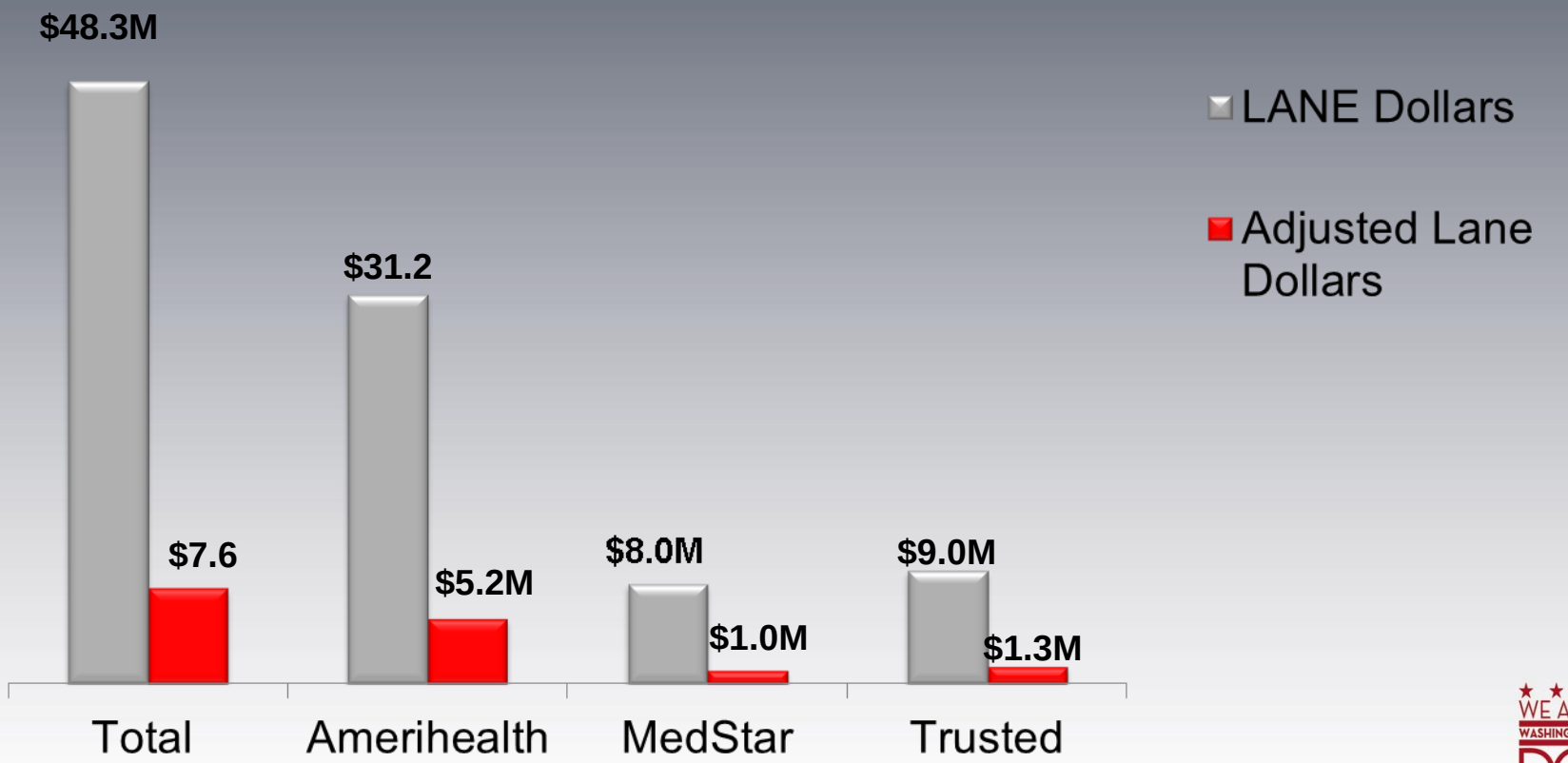
Source: Encounter data submitted by MCOs to DHCF.

Cost Of Low Acuity Visits Calculated During The Period From January 2015 to June 2015 Reaches $7.6 Million

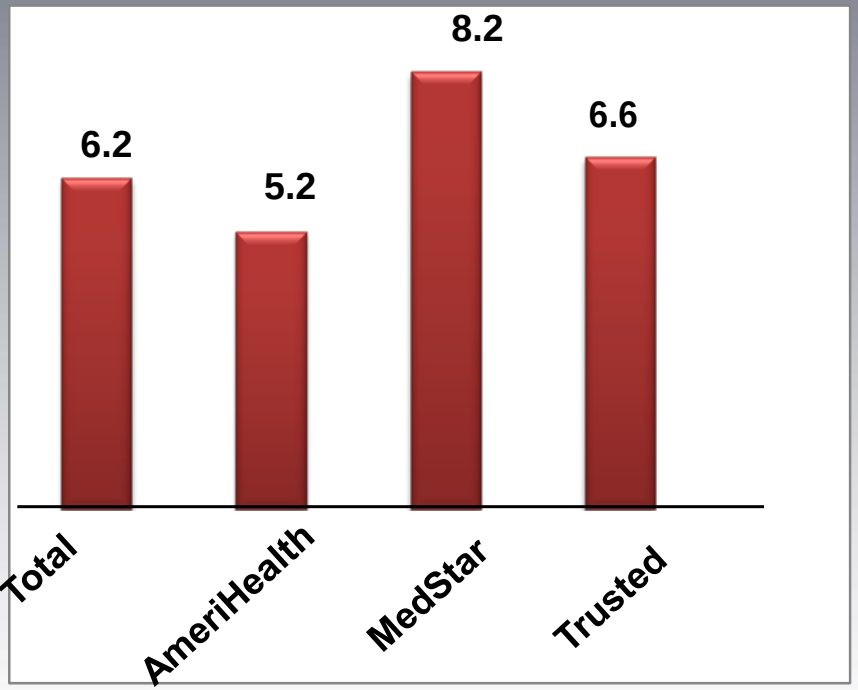


Notes: The LANE dollars are adjusted for the duration of enrollment and percent credibility factors are applied to each diagnosis based on professional judgment.

Source: MCO Encounter data reported by the health plans to DHCF.

Over Six Of Ten Inpatient Admissions Are Potentially Avoidable Costing $10.6 Million

Adjusted Potentially Avoidable Admissions As A Percent Of Inpatients Admits



Managed Care Plan	Cost Of PPA	Adjusted Avoidable Admits Per 1000
AmeriHealth	$4,803,496	5.26
MedStar	$3,999,526	8.2
Trusted	$1,916,151	6.6
Total	$10,619,173	6.2

Note: Results are based on prevention quality indicators developed by the Agency for Healthcare Research and Quality (AHRQ) that can be used with hospital discharge data to identify potentially preventable admissions for adults.
Source: MCO Encounter data provided by MCOs to DHCF.

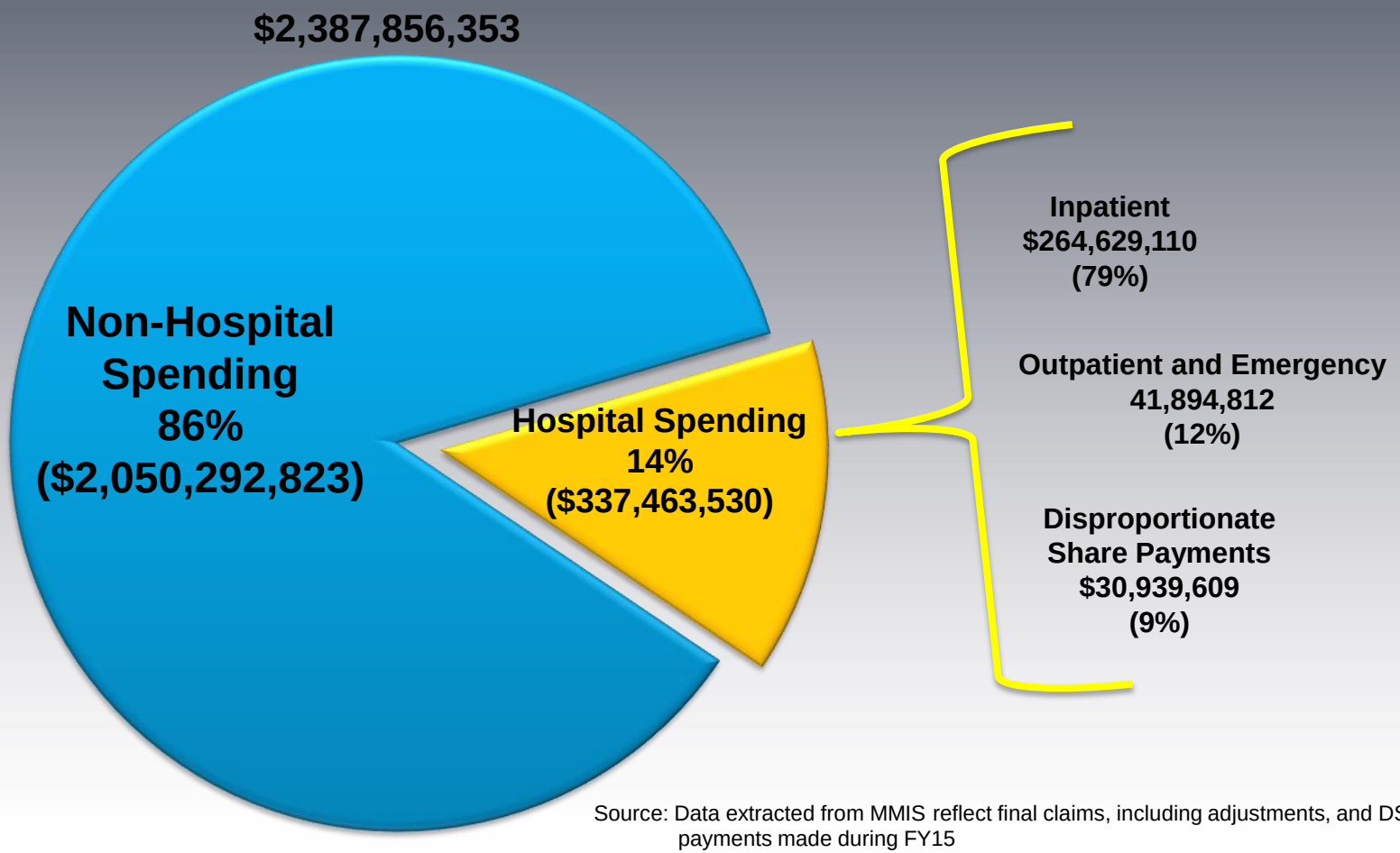
Hospital Readmissions Within 30 Days Carry Considerable Cost

Managed Care Plan	Ratio Of Hospital Readmissions To Index Hospital Admissions	Total Cost Of Readmissions
AmeriHealth	1 to 12.6	$9,543,434
MedStar	1 to 11.1	$6,255,786
Trusted	1 to 9.9	$2,313,035
Total	1 to 11.3	$18,112,256

The Average Cost Per Readmissions For Each Health Plan

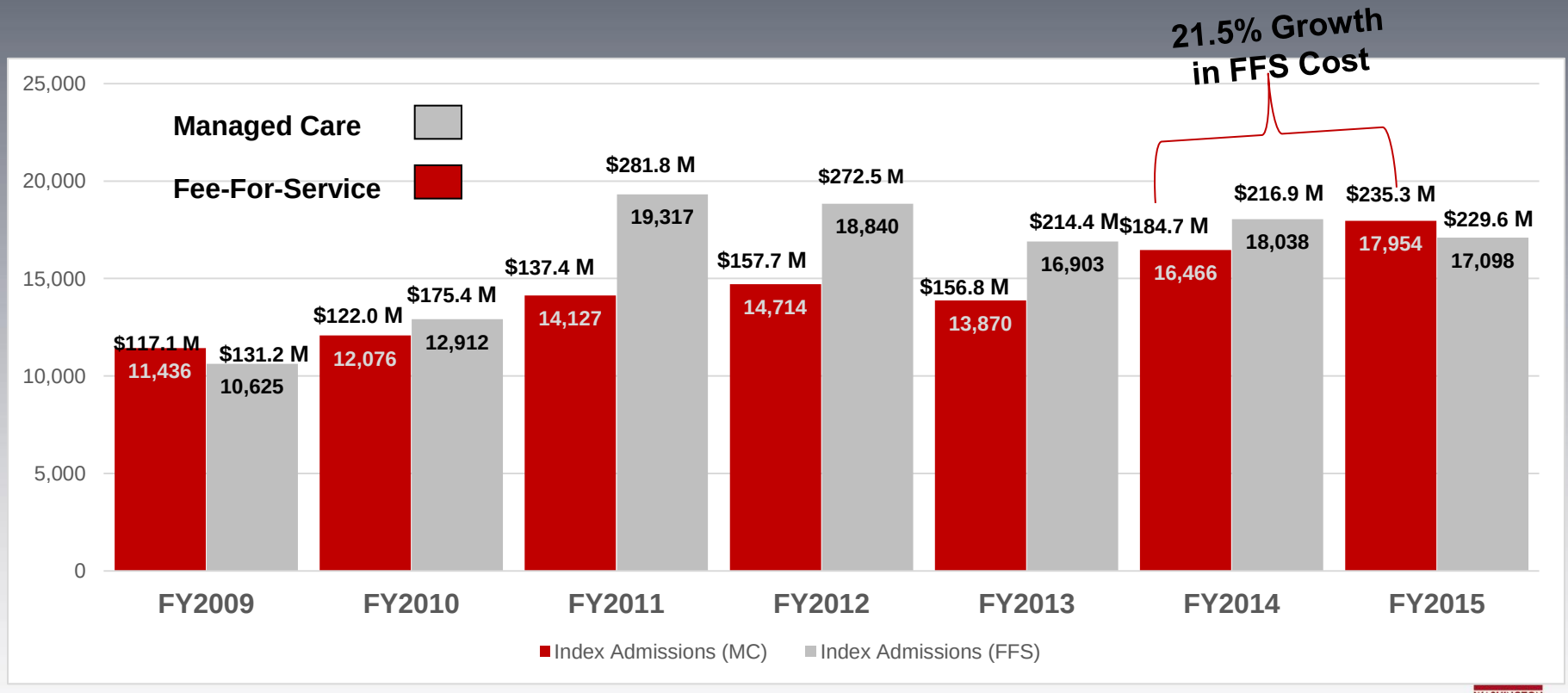
Note: All-cause 30-day hospital readmissions are "hospitalizations that occur, for any reason, within 30 days of discharge from an index admission." An index admission is defined as any inpatient stay that might produce an avoidable readmission" (Mathematica, 2011). Index admissions are derived from the set of unique hospital stays, and are determined by excluding specific categories of admissions from the set of unique hospital visits such as transfer cases and deaths. Readmission rates are computed as the ratio of admissions that occur within the specified readmission time period to the number of index admissions.

FFS Medicaid Hospital Spending Is Almost 15% Of Total Medicaid Expenditures



Source: Data extracted from MMIS reflect final claims, including adjustments, and DSH payments made during FY15

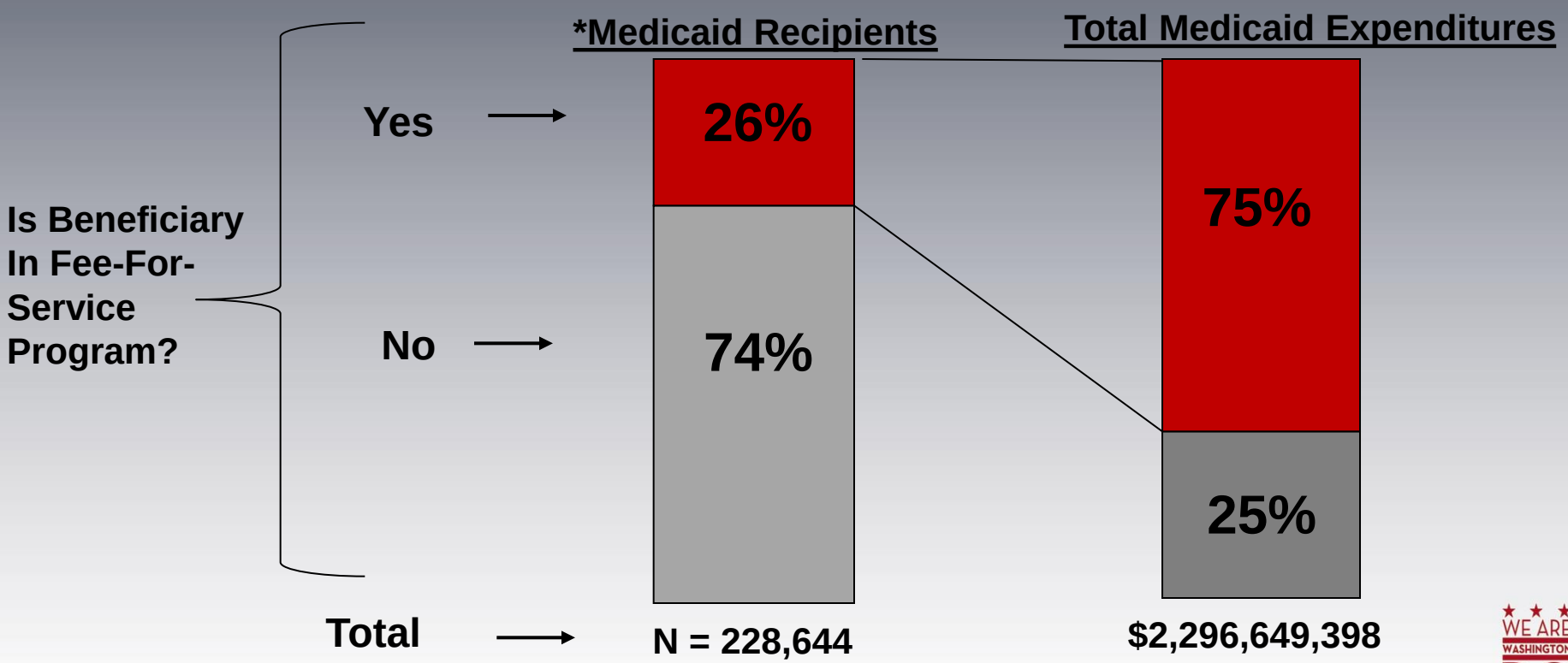
Fee-For Service Hospital Admissions Are Growing Faster Than Observed For Managed Care



Note: Index hospital admissions are obtained by subtracting non-candidates for readmissions from total hospital admissions

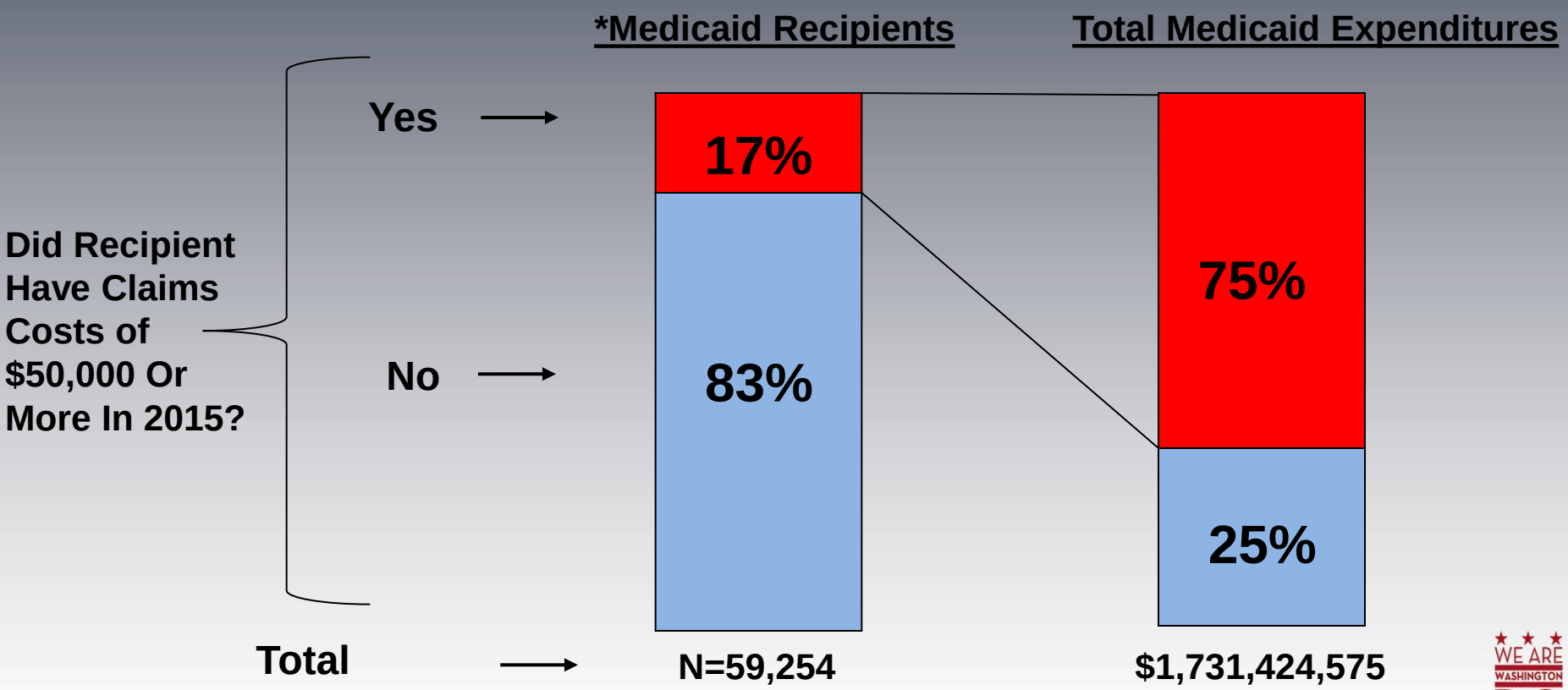
Source: DHCF staff analysis of data extracted from MMIS

Fee-For-Service Recipients Are Responsible For A Disproportionate Share of Medicaid Spending



Source: Data from DHCF MMIS system. *Only persons with 12 months of continuous eligibility in CY2015 are included in this analysis

A Sub-Group Of High Utilizers Within The Fee-For-Service Population Account For nearly 80 Percent Of All Spending On This Group



Note: Data from DHCF MMIS system. *Only persons in the Fee-For-Service program with 12 months of continuous eligibility in CY2015 are included in this analysis

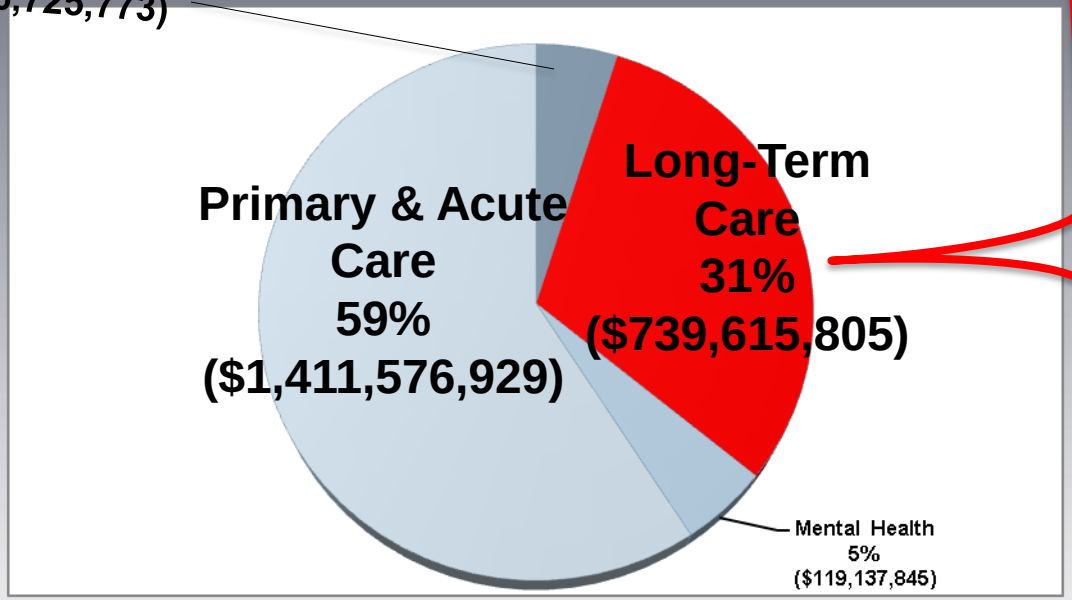
Comparison of High And Low Cost FFS Recipients

Characteristic	High Cost Group	Low Cost Group
Average Age	57	49
Average Hospital Admissions	3	1
Average Length of Stay (In Days)	9	6
Average Emergency Room Visits	4	2
Mean Prescriptions Per Person	54	27
Percent with Multiple Chronic Conditions	86%	61%

Note: High cost is defined as having continuous eligibility for 12 months and at least $50,000 in claims.

- ☐ Overview Of District's Budget For FY2015
- ☐ Budget Development For DHCF
- ☐ Medicaid And Alliance Enrollment Trends
- ☐ Status Of Automated Medicaid Eligibility System
- ☐ Medicaid Acute Care Expenditure Patterns
- ☑ **Medicaid Long-Term Care Expenditure Patterns**
- ☐ DHCF's Major Activities Planned For FY2017

Total Medicaid Program Expenditures, FY2015
$2,387,856,353



- Nursing Homes 31% ($232.8)
- DD Waiver 26% ($190.7)
- PCA Benefit 24% ($176)
- EPD Waiver 5% ($35.3)
- ICF/MR 13% ($95.1)
- Other 1% ($9.6)

Source: Data extracted from MMIS, reflecting claims paid during FY2015

Though High, Waiver Program Cost Compare Favorably To Institutional Spending

Program Service	Total Number of Recipients	Total Cost for Services	Average Cost Per Recipient
DD Waiver*	1,671	$190,701,895	$114,124
ICF/DD	345	$95,143,327	$275,778
EPD Waiver	2,856	$35,302,483	$12,361
State Plan Personal Care	5,300	$176,035,626	$33,214
Nursing Facilities	3,707	$232,783,948	$62,796

Source: Data extracted from DHCF's MMIS. *DD Waiver costs do not include DDS local funds for the waiver.

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Key Activities Planned For FY2017

Activity	Description	Goal of Project	Status
Health Homes Care Coordination	Develop a pilot program to test the efficacy of care coordination for Medicaid beneficiaries with chronic illness.	To strengthen primary care services and improve health outcomes for individuals with chronic illness. This program targets approximately 25,000 FFS and MCO beneficiaries with chronic illness and high costs.	SPA is being designed and will be submitted to CMS for approval; expected launch date is January, 2017.
Medicaid Long-Term Care Reform	Develop an improved system of long term care using a NO WRONG DOOR approach to program entry, streamline eligibility, conflict-free, comprehensive, and automated assessments of patient need, alignment of eligibility criteria with assessments, and improved program monitoring and oversight	Improve the timeliness of the application process, eliminate fragmentation in the long-term care system, reduce inappropriate growth, strengthen program oversight and services	ADRC established as the entry point for EPD waiver – will expand to other LTC services in FY17; DHCF is developing EPD waiver renewal application, to be effective 1/1/17
Pay For Performance Program for Managed Care Plans	Establish a program that requires the three full risk-based health plans to meet performance thresholds or lose a portion of their capitated payments	Improve care coordination outcomes	Program implemented in February 2016; DHCF will monitor MCOs to determine if benchmarks are met or if funds will be withheld.

Key Activities Planned For FY2017

Activity	Description	Goal of Project	Status
Development of the DCAS Eligibility System	In conjunction with DHS, develop and implement a new health and human services eligibility system for Medicaid and other public assistance programs	Establish an automated eligibility system that allows applicants to Medicaid and other assistance programs to apply for benefits through an online automated process.	DHCF, DHS, and Exchange staff are presently working to improve functionality; preparing for the third phase of the project
Rate-Setting for Several Provider Groups	Through the recently established Office of Rates , Reimbursement and Financial Analysis, DHCF will implement cost report audits on several major providers to more accurately identify their Medicaid allowable cost in support of the development of updated rate methodologies	Establish or refine the rate methodologies for the personal care program, ICF/IDD providers, and Federal Qualified Health Centers.	Cost reports for FQHCs, ICF/IDDs, and Home Health Care agencies have been collected and are now being audited
Access to Healthcare Services	Develop an access plan demonstrating beneficiary access to providers, provider availability, service utilization, and compare Medicaid and private rates in accordance with new CMS requirements	Ensure access to healthcare services for Medicaid beneficiaries	DHCF access plan will be submitted to CMS in June. Access to care reviews will be conducted every 3 years for primary, specialty, behavioral health, obstetric, and home health services